REPORT AS TO PROPOSED PILOT PROJECT ON THE ELECTRONIC MONITORING OF FORENSIC MENTAL HEALTH PATIENTS

PREPARED FOR:

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

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TABLE OF CONTENTS

EXECUTIVE SUMMARY .................................................................................................................................. 5

I. Introduction .................................................................................................................................................. 11

II. Background ................................................................................................................................................ 13

III. Mental Disorder Provisions of the Criminal Code .................................................................................. 16
    A. History .................................................................................................................................................... 16
    B. Dispositions and Conditions Under the Mental Disorder Provisions .............................................. 17

IV. Background Information: EM as a Tool for Monitoring Forensic Mental Health Patients Exercising Community Access .................................................................................................. 21
    A. Risk to Public Safety Posed by Forensic Mental Health Patients Exercising Community Access .............................................................................................................................................. 22
       1. Significant Threat to the Safety of the Public ......................................................................................... 22
       2. Risk to the Public Specific to Absconding When on Leave ................................................................. 24
    B. Effectiveness of EM in Reducing Risk to Public Safety ........................................................................ 27
    C. Effectiveness of Other Monitoring Methods ....................................................................................... 32

V. Criminal Code / Administrative Law Analysis ......................................................................................... 35
    A. Source of Legal Authority to Require EM in an Individual Case ......................................................... 36
    B. Limits on Legal Authority Under Criminal Code and Administrative Law ........................................ 39
       1. The Statutory Standard in Light of Administrative Law Principles .................................................. 39
          a) Applicable Standard of Review ........................................................................................................ 39
          b) Legal Expectations Under the Standard of Review ......................................................................... 40
    C. Application of the Statutory / Administrative Law Standard ................................................................ 42
       1. EM as a Necessary Condition of Community Access (“blanket” policy) ...................................... 42
       2. EM as a Requirement Based in Individualized Risk Assessment v. the Status Quo ..... 43
D. Conclusion on Criminal Code / Administrative Law Analysis ........................................... 46

VI. Relevance of Information Legislation ............................................................................. 46

VII. Charter .......................................................................................................................... 47

A. Life, Liberty and Security of Person (Section 7) ................................................................ 47
   1. Liberty Interest .............................................................................................................. 48
   2. Security Interest .......................................................................................................... 52
   3. Principles of Fundamental Justice ............................................................................... 54
      a) Arbitrariness ........................................................................................................... 55
      b) Overbreadth ............................................................................................................. 56
      c) Gross Disproportionality ......................................................................................... 59
   4. Conclusion on Section 7 Analysis ............................................................................... 59

B. Search and Seizure (Section 8) ....................................................................................... 60
   1. Reasonable Expectation of Privacy ............................................................................ 61
      a) Does the Claimant Have a Reasonable Expectation of Privacy? ................................. 62

C. Detention or Imprisonment (Section 9) ......................................................................... 66
   1. Is There a Detention or Imprisonment? ...................................................................... 66
   2. Is the Detention Arbitrary? ......................................................................................... 66

D. Treatment or Punishment (Section 12) ......................................................................... 68
   1. Is an EM Policy “Treatment or Punishment”? ............................................................. 68
   2. Is the Treatment “Cruel and Unusual”? ....................................................................... 68

E. Equality Rights (Section 15) ......................................................................................... 69
   1. Does an EM Policy Create an Adverse Distinction on the Basis of Mental Disability? 70
   2. Does the Law Have as Its Object the Amelioration of Conditions of Disadvantaged
      Individuals or Groups Such That Section 15(2) Is Engaged? ........................................... 71
3. Does the Distinction Create a Disadvantage by Perpetuating Prejudice or Stereotyping?  
   a) Does the Discriminatory Effect of EM of ECFH Patients Perpetuate Prejudice? ..... 72  
   b) Is the Discriminatory Effect of EM of ECFH Patients Based on Stereotyped Views? 74

4. Conclusion on Section 15 .................................................................................................. 76

F. Guarantee of Rights and Freedoms (Section 1) ................................................................. 76

1. Is the Limit Prescribed by Law? .................................................................................. 77
2. Is the Purpose for Which the Limit Is Imposed Pressing and Substantial? .............. 77
3. Are the Means by Which the Legislative Purpose Is Furthered Proportionate? ........ 77
   a) Is the Limit Rationally Connected to the Purpose? .............................................. 77
   b) Does the Limit Minimally Impair the Charter Right? ........................................ 78
   c) Is the Law Proportionate in Its Effect? ................................................................. 80
4. Conclusion on Section 1 ................................................................................................. 81

VIII. Human Rights Legislation .......................................................................................... 82

A. Introduction .................................................................................................................. 82

B. Relevance of Statutory Human Rights ....................................................................... 82

C. What Is Required to Establish a Claim of Discrimination? ..................................... 83

1. Is There Prima Facie Discrimination? ................................................................. 84
   a) Do Forensic Mental Health Patients Have a Characteristic Protected From  
      Discrimination Under the Act? .......................................................................... 84
   b) Do Forensic Mental Health Patients Experience an Adverse Impact With Respect to  
      the Service? ...................................................................................................... 84
      1) Is There a “Service”? .................................................................................. 85
      2) Is There an Adverse Impact? ........................................................................ 86
   c) Is the Protected Characteristic a Factor in the Adverse Impact? .................. 86
2. Is the Discrimination Justifiable? ............................................................................. 87
a) Is the Policy Adopted for a Purpose or Goal Rationally Connected to the Function Being Performed? ................................................................................................................. 87

b) Is the Policy Adopted in Good Faith, in the Belief That It Is Necessary for the Fulfilment of the Purpose or Goal? .................................................................................................................. 88

c) Is the Standard Reasonably Necessary to Accomplish the Purpose or Goal? Can the Claimant(s) Be Accommodated Without Undue Hardship? ......................................................................................... 89

1) Process ........................................................................................................................................................................... 89

2) Substantive Content ......................................................................................................................................................... 90

   (i) Is EM Reasonably Necessary to Protect Public Safety? ...................................................................................... 91

   (ii) Are There Alternatives or Different Ways of Implementing That Could Fulfil the Purpose? ........................................... 93

D. Conclusion on Human Rights Legislation .............................................................................................................................. 95

Appendix A – Select Criminal Code Sections .......................................................................................................................... 98

Appendix B – East Coast Forensic Hospital Process Changes Subsequent to 2012 ................................................................. 108

Appendix C – Safety in Numbers: New Violence Risk Management Tools ............................................................... 115

Appendix D – East Coast Forensic Hospital Processes Related to Community Access ................................................................................................................................. 117

Appendix E – Select Charter Sections .................................................................................................................................. 122

Appendix F – Select Nova Scotia Human Rights Act Sections ................................................................................................. 124
EXECUTIVE SUMMARY

A. Introduction

This report was undertaken in response to a request from the Nova Scotia government for assistance in identifying and analyzing legal issues related to the potential establishment of a pilot project. The project would involve the use of electronic monitoring (EM) of forensic mental health patients (patients) detained at the East Coast Forensic Hospital (ECFH) who are exercising indirectly supervised and unescorted community access (community access).

The purpose of our analysis is not to determine if an EM policy or its application violates any laws. Rather, the purpose is to consider whether there are factors that may support legal challenges and ensure government is aware of their relevance to the potential implementation of the proposed pilot project. The relevance of these issues will need to be revisited as details of an EM policy, if any, are developed. We provide the following guidance based on the context of which we are aware. Our analysis does not constitute nor should it be construed as legal advice.

We understand that the purpose of the potential EM policy is to enhance public safety; it is not aimed at enhancing community access for patients. The government is considering three options:

- blanket policy requiring that all patients exercising community access wear a GPS bracelet;
- individualized risk assessment to determine whether a patient would be required to wear a GPS bracelet when exercising community access; or
- status quo where no patients would wear a GPS bracelet when exercising community access.

Recent changes to the Criminal Code prohibit patients designated by a court as a “high-risk accused” from exercising indirectly supervised and unescorted community access. This designation may be made in circumstances including where a court is satisfied there “is a substantial likelihood the accused will use violence that could endanger the life or safety of another person.”¹ As this population is barred from unescorted community access, we do not discuss this population in this report. For all other patients, the current policies and procedures for community access would continue, including those implemented in 2012-2013.

B. Background Information

This report canvasses information aimed at addressing the following key issues that relate to legal questions about the potential use of EM:

¹ “High-risk” is defined in section 672.64 of the Criminal Code. (See Appendix A).
risk to public safety posed by patients exercising community access while under a hospital detention order;
- effectiveness of EM in reducing risk to public safety; and
- effectiveness of other monitoring methods in reducing risk to public safety.

Many of the legal tests that are reviewed in this report involve weighing the risk to public harm, where the magnitude of the harm must be balanced as against its probability. The information that we have reviewed suggests a low probability of risk materializing. As we understand the information available, it is not clear that EM would reduce the probability of the risk materializing. However, there is little to no information on the magnitude of harm should the risk materialize – it could be minor, it could be horrific. Some mental health professionals have expressed concern that the use of EM could be counter-productive to therapy and have the unintended effect of exacerbating risk. Staff at the ECFH believes that the policies and procedures implemented in 2012-2013 have reduced absent without leave (AWOL) incidents and enhanced rehabilitation processes. It is difficult to determine with precision the overall impact of these changes due to the low frequency of violence prior to and since the changes. As the government considers the potential use of EM, it will be important to assess whether a correlation exists between the incidence of violence and patients being off of their itinerary or staying out past the expiry of their community access pass, and the conclusion that EM likely would facilitate prevention of the violence.

We understand that the government is conducting research independent of this report regarding the impact and effectiveness of EM in the forensic mental health population.

C. Analysis

We identify three sources of law that are engaged by the potential use of EM: the Criminal Code and administrative law; the Canadian Charter of Rights and Freedoms (Charter); and statutory human rights law. We also briefly examine the relevance of information legislation.

1. Criminal Code and Administrative Law

The Criminal Code requires that dispositions of a Review Board concerning a patient, and any conditions attaching to the disposition, be “necessary and appropriate” taking into account the safety of the public, the mental condition of the patient, the reintegration of the patient into society and the other needs of the patient. Pursuant to case law, the Charter has required that the disposition be based on an individualized assessment, and be the least onerous and least restrictive disposition. Hospital decisions must also comply with these requirements. Where a disposition or condition is appealed, the reviewing court will show deference to the decision of the Review Board or hospital in applying a standard of reasonableness. However, given that a decision to impose EM engages Charter values (that of liberty, and perhaps also equality, as well
as privacy or dignity) a reviewing court would expect “proportionality” as between the positive
effects of the decision in advancing the statutory mandate and its negative effects on Charter
interests.

Based on the information we have reviewed and, in particular, what we understand to be a lack
of information that EM is or would be effective in preventing violence, there is an arguable case
that a decision of the Review Board or hospital requiring EM as a condition of community access
could be established as unreasonable due to a lack of proportionality and, therefore, invalid. It
appears that the third option being considered by government, i.e. maintenance of the status quo,
is most clearly consistent with the requirements of the Criminal Code as interpreted in light of
administrative law principles. The two options being considered by government that involve the
use of EM may not be consistent with the requirements of the Criminal Code. Even though a
court is to assess proportionality in a manner that shows deference to expert decision-makers,
without evidence that EM is reasonably likely to prevent not only AWOL incidence but in
particular incidence of violence, we suggest that a claimant has a reasonable chance of success.
A decision applying a “blanket” requirement of EM for all patients accessing leave would likely
be found to breach the statutory standard. The susceptibility of a decision based in an
individualized risk determination would depend on factors such as how closely tailored the risk
determination and supervision tools were to the goal of protecting the public in a manner that is
“necessary and appropriate” as well as least restrictive and onerous for the patient in the
circumstances.

2. Charter

a) Section 7

*Everyone has the right to life, liberty and security of the person and the right not to be
deprived thereof except in accordance with the principles of fundamental justice.*

The first step of a section 7 challenge is to establish that the interest in life, liberty, or security of
the person is engaged by the impugned law or policy. We have concluded that liberty, and
perhaps also security of the person, are likely engaged by a policy imposing EM as a condition of
leave. The second step is to demonstrate that the government action in question is inconsistent
with the principles of fundamental justice. We discuss three principles of fundamental justice:
the rules against arbitrariness, overbreadth, and gross disproportionality. These principles
require consideration of the Criminal Code requirements for conditions that are “necessary and
appropriate in the circumstances” consistent with public safety and the patient’s needs, and also
consistent with the jurisprudence requiring the conditions be the least onerous and least
restrictive. There is an arguable challenge under the heads of arbitrariness and overbreadth
because the links between being AWOL and acts of violence are unclear and there appear to be
less restrictive alternatives available that would address the goal of public safety (for example,
the changes implemented in 2012-2013 at the ECFH). However, the case law regarding arbitrariness and overbreadth is still in development and, depending on the circumstances, may allow for some flexibility or deference to government where laws or policies are based on speculation, as long as the speculation is reasonable and so not in disregard of, for example, the known evidence.

It is unlikely that a claimant would succeed under the head of gross disproportionality.

b) Section 15

Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on ... mental ... disability.

Section 15 is aimed at preventing discriminatory distinctions that impact adversely on members of a protected class. It is likely that an adverse distinction could be established on the basis that the requirement for EM imposes a restriction or burden that falls exclusively on individuals based on mental illness. A court will consider whether the distinction perpetuates prejudice/disadvantage or is based on stereotyped views. We conclude that a law or policy imposing EM as a condition of leave is likely to be deemed “discrimination” under section 15. There is little chance that a blanket policy imposing EM could withstand scrutiny under section 15 because it does not take into account the needs, capacities and circumstances of the patient. While there is a possibility that government, with evidence, could establish that an EM policy based on individual risk assessment accords with the “needs, capacities and circumstances” of patients, the law under section 15 recognizes that discrimination can be established where there is perpetuation of prejudice. Therefore, an EM policy based in individualized risk assessment also is arguably susceptible to being held to violate section 15.

c) Section 1

The Canadian Charter of Rights and Freedoms guarantees the rights and freedoms set out in it, subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

If a violation of the Charter is established, the government then has the opportunity under section 1 to demonstrate that the infringement is justified. The justification analysis under section 1 would require the government to establish that the goal of public safety is pressing and substantial and that the effects of an EM policy are proportionate with the goal. It appears that a pressing and substantial purpose could be established. However, the government would face challenges under the proportionality stage of the test that includes the elements of rational connection, minimal impairment and proportionality. We note that the courts sometimes show a level of deference to governments making complex social decisions. If a Charter violation was
made out, the ability to justify an EM policy under section 1 would depend on government’s ability to establish the effectiveness of EM in preventing violence and that EM is the least restrictive means of achieving that goal. When considering whether the effects of an EM policy are proportionate to the goal of improving public safety, the key issue will be whether the likely salutary effects (in terms of enhanced public safety) are outweighed by the likely effects on the Charter interests engaged, including the prospect of increased stigma experienced by patients. We suggest that if a violation of the Charter is established, it may be challenging for the government to demonstrably justify its policy under section 1.

d) Sections 8, 9 and 12

We also considered the application of sections 8, 9 and 12 of the Charter to a requirement for the use of EM. We found that a claim under section 8 (unreasonable search and seizure) is unlikely to succeed. With respect to section 9 (arbitrary detention or imprisonment), much will depend on how the standards are drafted. It is more likely that a blanket policy would be at risk of challenge than would an EM policy based on individual risk assessment. It is unlikely that a successful claim would be brought under section 12 (cruel and unusual treatment).

3. Statutory Human Rights

There are two stages to establishing a claim of discrimination under the provincial Human Rights Act. First, a claimant needs to demonstrate prima facie discrimination by showing that they experience an adverse impact, based on a protected ground (mental illness), with respect to a service (forensic hospital services). Under the Act, prima facie discrimination will be found where a distinction has the ‘effect of imposing burdens, obligations or disadvantages’ on a class of individuals not imposed on others. Information about stigma and stereotypes, as well as the practical obligations of physically wearing the GPS device would be considered. It would appear that a policy (whether blanket or individualized) requiring EM is likely to be recognized as placing a burden on patients at least in part based on their mental illness such that prima facie discrimination would be made out. The second stage considers whether the government can justify a prima facie discriminatory policy by demonstrating that the policy is adopted for a purpose that is rationally connected to the function/service (forensic hospital services), that it is adopted in good faith and that the standard is reasonably necessary to accomplish the goal and cannot be accomplished through alternative approaches that do not have a discriminatory effect. These issues and the state of the information related to them are discussed in the above analysis presented in this summary, and so we will not repeat it here.

A claimant has a significant likelihood of success where a challenge to a law, policy or decision imposing EM as a condition of leave is based in the principles of statutory human rights law. In particular, such a claim (which may be engaged through the requirement that the Review Board apply human rights legislation in matters properly before it, or, potentially, through a human
rights proceeding targeting a hospital decision) may have a greater likelihood of success than a *Charter* claim. While “discrimination” is likely to be established whether through section 15 of the *Charter* or the *prima facie* stage of a human rights claim, statutory human rights principles do not include the imperative of deference to government as is often engaged under section 1 of the *Charter*.

This conclusion is subject to the caveat that the human rights legislation has a unique provision that has language which is very similar to section 1 of the *Charter*. This provision has not, to our knowledge, been judicially considered. If it is interpreted to be consistent with section 1 *Charter* jurisprudence, then a decision-maker may show deference to the government and the likelihood of success will be similar to that described above for a section 15 challenge.
I. Introduction

This report was undertaken in response to a request from the Nova Scotia Department of Health and Wellness (DHW) for assistance in identifying and analyzing legal issues related to the potential establishment of a pilot project involving the use of electronic monitoring (EM) of forensic mental health patients detained at the East Coast Forensic Hospital (ECFH) when exercising indirectly supervised/unaccompanied community access. Our analysis is offered for the purpose of providing guidance for policy development and specifically for supporting the DHW in providing advice to the Minister. Our analysis does not constitute nor should it be construed as legal advice.

Our analysis is based on a number of assumptions:

- We are providing an analysis for the purposes of the DHW assessing the potential implementation of a pilot project.
- The purpose of the pilot project would be to improve public safety.
- The pilot project would involve patients under a designation of being “not criminally responsible on account of mental disorder” (NCR) or “unfit to stand trial” who have a disposition by the Nova Scotia Criminal Code Review Board (Review Board) of “detention in a hospital subject to conditions it considers appropriate” under the Criminal Code section 672.5(c).
- The EM would involve the use of a GPS-based tracking device that would likely be in the form of an ankle or wrist bracelet.
- If a pilot project proceeds, the evidence that is gathered through the pilot project will be used to re-evaluate the policy analysis/recommendations.
- The DHW is considering three options in relation to a potential pilot project:

  1. Blanket policy - There would be a requirement that all community access is subject to the patient wearing a GPS bracelet.

  2. Individual risk assessment - There would be an individual risk assessment for each patient made by the treatment team. This assessment would likely include attention to both risk of flight and risk of harm, and would be used to determine whether wearing a GPS bracelet is made a mandatory condition of community access. If the individualized risk assessment does not result in a recommendation that the

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2 Throughout this document we refer to the ECFH, but we recognize that it is part of the Capital District Health Authority and that some decisions are made at the health authority level. As such, a legal complaint could be directed at the health authority instead of, or in addition to, the ECFH.
community access be contingent on the use of EM, the patient would not be required to wear a bracelet in order to be granted community access, and normal policies would continue to apply. The assessment would include examination of whether the bracelet is contraindicated for health or other reasons.

3. Status quo - GPS bracelets would not be used to monitor patients exercising community access.

- Under either of the first 2 options, it would be possible for a patient to refuse to wear the GPS device. If a bracelet is a mandatory condition of community access, community access would not be granted if the patient refuses to wear the bracelet.
- Under either of the first 2 options, community access would not be granted for a patient who is required to use electronic monitoring in order to exercise community access, but for whom use of electronic monitoring is contraindicated for health or other reasons.
- For the purposes of the pilot project, the bracelet would not be intended to be used to enhance community access. When recommended for use, the intention would be to use the bracelet as an additional means to monitor or supervise a patient so as to enhance public safety.

We note that the Criminal Code was amended between the time when the Health Law Institute was asked to prepare this report, and when it was completed. One change is that the Criminal Code introduced the category of “high-risk accused.” Under section 672.64, a person who is NCR or unfit to stand trial may be determined by a court to be a “high-risk accused” if

(a) the court is satisfied that there is a substantial likelihood that the accused will use violence that could endanger the life or safety of another person; or

(b) the court is of the opinion that the acts that constitute the offence were of such a brutal nature as to indicate a risk of grave physical or psychological harm to another person.3

Where a court makes this disposition, the accused may not be absent from the hospital unless he/she is escorted. These individuals are therefore ineligible for indirectly supervised community access and so we do not consider this population in our analysis.

3 Criminal Code, RSC 1985, c C-46, s 672.64(1).
II. Background

In April 2012, a patient who was exercising a one-hour indirectly supervised community access pass did not return to the ECFH on time and was reported to the police as absent without leave (AWOL). While the patient was AWOL, a violent incident occurred resulting in the death of a young man. The patient has been charged with second degree murder. Subsequently, the province called for a review of the community access granted to NCR persons at the ECFH. The review, led by the Departments of Justice and Health and Wellness, and the Capital District Health Authority (Joint Review), issued a report in September 2012.

The Joint Review engaged independent mental health experts in the field of forensic psychiatry, Drs. Alexander Simpson and Johann Brink, to conduct separate reviews that would inform provincial and hospital action. These external reviews examined the policies and practices of the ECFH relating to community access, supervision of patients when accessing the community, and notification of the public in the case of AWOL patients. They found the policies and procedures of the ECFH to be in line with other forensic mental health hospitals in Canada and a number of them “to be leading practice.” However, the Joint Review identified significant gaps and outlined 18 actions designed to ensure improvements were made to increase public protection. All 18 actions have been implemented. As part of its work, the Joint Review considered the use of GPS tracking of NCR patients. In that regard, the report reads:

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4 Nova Scotia, Department of Health and Wellness, Department of Justice & Capital District Health Authority, Joint Review of the East Coast Forensic Hospital’s Community Access Privileges, (Nova Scotia: 2012) online: <http://novascotia.ca/just/ECFH_Review/Joint-Review.pdf> at 1. “Dr. Simpson concluded the ‘policies and procedures are similar to those commonly employed across Canada, and in a number of key areas, they are superior to many other forensic program’s policies.’ Dr. Brink also found them [to be in] in ‘broad alignment with other forensic hospitals in Canada’ and found a number of those policies to be leading practice.”


This review also considered the adoption of GPS tracking of not-criminally-responsible persons. GPS tracking technology should not, at this time, be adopted in Nova Scotia. This technology has not yet been adopted by any forensic facilities in Canada.

Dr. Simpson points out that GPS tracking is “novel in the mental health field.” It is unclear what effect the use of GPS technology may have on a patient’s treatment. Concerns have also been expressed about whether this could be an unreasonable and discriminatory infringement on the rights of people with mental illness found to be not criminally responsible.

Additional research is needed to determine if this technology is effective in forensic populations. Further consideration surrounding the ethics of its use and its impact on treatment and patient progress are also needed before good policy decisions can be made.\(^7\)

We understand from the DHW that no other Canadian jurisdiction uses, or is considering use of, EM with forensic mental health patients.

The Health Law Institute has been engaged to explore certain legal questions – in particular, human rights considerations – of central relevance to the decision of government about whether to pursue GPS tracking of some or all forensic mental health patients subject to a hospital disposition and granted community access.

In what follows, we begin with the overarching legal framework (under Part XX.1 of the Criminal Code) governing the care and supervision of the forensic mental health population. Next, we outline certain factual questions (and our understanding of the background information on those questions) that are of primary significance to the analysis that we have conducted. These are:

- What, if any, risk to public safety is posed by patients exercising community access while under a hospital detention order?
- What, if any, effect does EM have on reducing any risk to public safety?
- Are there alternative, less restrictive means for monitoring community access that would achieve the legislative goals, including an acceptable level of public safety?

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The following analysis builds on the above-noted statutory and factual foundations to address, in turn, the following sources of law as they are engaged by the present inquiry:

1. the *Criminal Code* (and administrative law principles);

2. the *Canadian Charter of Rights and Freedoms* (“Charter”); and

3. statutory human rights law.

Our task was to provide comments regarding an as-yet-unspecified pilot program relating to EM. As a part of this work, we have considered legal issues that may arise if EM were imposed as a supervisory condition in an individual case. Several leading legal judgments interpreting and applying the Mental Disorder provisions of the *Criminal Code* (Part XX.1) have arisen out of challenges to supervisory conditions imposed through the exercise of individualized discretion (for instance, *Pinet*\(^8\) and *Tulikorpi*\(^9\)). Moreover, the analysis of the limits of discretion imposed under the statutory framework of the *Criminal Code* is a useful starting-point for determining whether EM is likely to fall within the scope and limits of applicable Canadian law.

We first introduce the test set out in the *Criminal Code* and the case law interpreting it, as well as the likely effect of amendments made to the *Criminal Code* that came into force July 11, 2014. The case law sets out the court’s approach to the analysis of issues concerning proportionality, liberty and Charter values in the context of the relevant *Criminal Code* provisions. Immediately after this discussion we turn to section 7 of the *Charter* (life, liberty and security of the person) which expands on the concept of liberty and addresses the concept of security of the person. We then address other sections of the *Charter* that may be engaged that relate to and expand upon the concept of liberty. Specifically, we address sections 8 (search and seizure), 9 (cruel and unusual treatment) and 12 (arbitrary detention). We conclude our *Charter* discussion with section 15 (equality) which protects against discrimination. Finally, we conclude the report with a discussion of statutory human rights law which provides a distinct analysis for the protection against discrimination.

The above framework of analysis takes account of different ways that human rights considerations are engaged by our inquiry into the legality of EM as a means of monitoring forensic mental health patients on community access. At the same time, the analysis distinguishes the legal frameworks appropriate to two distinct types of governmental action that may be taken with respect to EM: individualized discretionary decisions exercised under a general rule (i.e., a decision of the Review Board or the ECFH staff to require EM in a particular

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\(^8\) *Pinet v St. Thomas Psychiatric Hospital*, 2004 SCC 21, 1 SCR 528.  
\(^9\) *Penetanguishene Mental Health Centre v Ontario (Attorney General)*, 2004 SCC 20, 1 SCR 498 [“Tulikorpi”].
case, under the broad discretionary power to set conditions of supervision under Part XX.1 of the Criminal Code) versus a law or policy that expressly contemplates EM or conditions for requiring EM. Individualized discretion must be exercised in accordance with administrative law principles, which require the balancing of statutory purposes and Charter values. In contrast, a law or policy that expressly institutes a standard attracts the direct application of the Charter. Statutory human rights law spans this divide, and is available as an additional or alternative basis for challenging either individualized discretion or law/policy.

The purpose of our analysis is not to determine if an EM policy or its application violates the Criminal Code, the Charter or human rights legislation. Rather, the purpose is to consider whether there are factors that may support legal challenges and ensure government is aware of the relevance of these areas of law as they could be applied to a requirement that some or all forensic mental health patients wear a monitoring device when exercising community access. The relevance of these issues will need to be revisited as an EM policy, if any, is developed. We provide the following guidance based on the detail and context of which we are aware and which we identify in this report.

We note that jurisdictions outside Canada may have considered the use of EM. We have not considered the legality in other jurisdictions as the constitutional frameworks are different as is the subordinate legislative context. We confine our review to the Canadian legal context, and to Nova Scotia in particular, while drawing cautiously on studies from other jurisdictions.

III. Mental Disorder Provisions of the Criminal Code

This part of the report places in context the section of the Criminal Code that deals with persons found NCR or unfit to stand trial: Part XX.1, or the Mental Disorder provisions of the Criminal Code. We outline certain key statutory requirements concerning the types of orders and conditions that can be made in relation to an individual who is subject to the Mental Disorder provisions. The analysis of the implications of these provisions for the proposal to institute a pilot project involving EM of forensic mental health patients on community access takes place later in this report, in Part V. The key provisions from the Criminal Code are reproduced in Appendix A.

A. History

Prior to 1992, the Criminal Code provisions addressing criminal acts and mental illness had been found in two court decisions to violate the Charter. In response, the federal government

\[R v Chaulk, [1990] 3 SCR 1303, SCJ No 139; R v Swain, [1991] 1 SCR 933, SCJ No 32.\]
introduced Part XX.1 of the *Criminal Code*, “based on a growing appreciation that treating mentally ill offenders like other offenders failed to address properly the interests of either the offenders or the public.”\(^{11}\) The 1992 changes were intended to achieve the twin goals of fair treatment of mentally ill offenders and public safety.\(^{12}\)

Instead of maintaining only the previous verdicts of either acquittal or conviction for mentally ill individuals, Part XX.1 introduced a “third alternative.”\(^\text{13}\) This third alternative meant that “once an accused person is found to have committed a crime while suffering from a mental disorder,” that individual is “diverted into a special stream.”\(^\text{14}\) Independent provincial Review Boards were created and granted the power to hear and make dispositions under section 672.54 of the *Criminal Code* as to whether “the person should be kept in a secure institution, released on conditions, or unconditionally discharged.”\(^\text{15}\)

Key provisions of Part XX.1 were modified in July 2014. As discussed below, the changes which are relevant for this report appear to be largely intended to codify judicial interpretations of the statutory provisions. As such, they do not appear to change the law but rather bring the statutory language in line with the jurisprudence.

While the powers and procedures of the Review Boards are set out in the federal *Criminal Code* (Part XX.1 Mental Disorder) and the *Inquiries Act*,\(^\text{16}\) the Review Boards are to “be treated as having been established under the laws of the province.”\(^\text{17}\) In October 2013, the Nova Scotia Criminal Code Review Board (Review Board) established rules for the first time providing for the practice and procedure before it, as permitted by section 672.44 of the *Criminal Code*.

### B. Dispositions and Conditions Under the Mental Disorder Provisions

When an individual is found unfit to stand trial or NCR, a court or a Review Board shall make one of three possible dispositions set out in section 672.54:

- an absolute discharge where the individual is not a significant threat to the safety of the public;
- a discharge subject to conditions the court or Review Board considers appropriate; or


\(^{13}\) *Winko v British Columbia (Forensic Psychiatric Institute)*, [1999] 2 SCR 625 at para 20, SCJ No 31.


\(^{16}\) *Criminal Code*, RSC 1985, c C-46, s 672.44.

\(^{17}\) *Criminal Code*, RSC 1985, c C-46, s 672.38(2).
• detention in a hospital\textsuperscript{18} subject to conditions the court or Review Board considers appropriate.

The statute (section 672.54) stipulates that the chosen disposition must be that which is “necessary and appropriate in the circumstances,” taking into consideration:

• the safety of the public, which is paramount;
• the mental condition of the individual;
• the reintegration of the individual into society; and
• the other needs of the individual.\textsuperscript{19}

The Review Board has broad authority and discretion to impose \textit{conditions of supervision} where it orders patients to be detained in hospital under the Mental Disorder provisions of the \textit{Criminal Code}. The legal limits to this discretion are the same limits (stated under section 672.54) as those placed on disposition orders. Therefore, any conditions attaching to a disposition order must meet the governing requirement that the conditions be “necessary and appropriate in the circumstance” when viewed in their entirety,\textsuperscript{20} considering:

- the safety of the public, which is paramount;
- the mental condition of the person;
- the reintegration of the person into society; and
- the other needs of the person.

In addition, the conditions must comply with the \textit{Charter}.\textsuperscript{21}

Section 672.54 and other sections of the Mental Disorder Part of the \textit{Criminal Code} were amended effective July 11, 2014. We only discuss the amendments relevant to the use of EM as a tool for patients whose disposition includes exercising indirectly supervised community access. We note the addition of a new category of court-designated high-risk individuals. These individuals are subject to the requirements set out in section 672.64 regarding community access. In particular, they are not permitted to be outside of the hospital unless they are escorted. Our discussion therefore does not relate to individuals subject to the high-risk accused provisions under the \textit{Criminal Code}.

\textsuperscript{18} All detentions under Part XX.1 are in hospital. The ECFH is designated as a hospital under s 672.1(1). See OIC 2000-260 (May 17, 2000).

\textsuperscript{19} \textit{Criminal Code}, RSC 1985, c C-46, s 672.54.


\textsuperscript{21} \textit{R v Conway}, 2010 SCC 22, 1 SCR 765.
There are three key amendments that relate to section 672.54. As discussed below, all appear to be intended to codify (or incorporate into legislation) the judicial interpretations of the existing statutory provisions, and so do not appear to be intended to introduce changes to the law. In addition to the three key amendments we discuss, we note that there is a new provision, section 672.542, which also appears to codify existing responsibilities of courts and Review Boards to consider the means of protecting public safety which may include a condition refraining the patient “from going to any [specified] place.”

The first amendment replaced an overarching statutory requirement that courts and Review Boards make a disposition that is “the least onerous and least restrictive to the accused” with the requirement that they make a disposition that is “necessary and appropriate in the circumstances.” At first blush, this appears to be a significant change. The amended section has not yet been judicially considered, but there is indication that “necessary and appropriate” is to be interpreted in a manner consistent with the previous requirement of “least onerous and least restrictive.”

In his remarks before a Senate Standing Committee that was considering the amendments, the Minister of Justice and Attorney General of Canada stated that the new language was not intended to eliminate the requirement that a disposition be the least onerous and least restrictive, but rather to make the concept easier to understand. The Minister stated that the “… wording was consistent with how this requirement was described in the 1999 Supreme Court of Canada decision Winko v. British Columbia (Forensic Psychiatric Institute), such that ‘the NCR accused’s liberty will be trammeled no more than is necessary to protect the public safety.’”

In the decision to which the Minister was referring, the Supreme Court of Canada had stated that the guiding objective for Review Boards when determining dispositions and conditions is to reconcile the twin goals of public safety and fair treatment of forensic mental health patients. The Court in Winko further stated that “[j]ustice requires that the NCR accused be accorded as much liberty as is compatible with public safety” and linked the disposition section’s Charter


23 We note that the phrase “fair treatment” is clarified in Mazzei v British Columbia (Director of Adult Forensic Psychiatric Services), 2006 SCC 7 at para 27, 1 SCR 326 as describing “fair legal process,” rather than the narrower objective of medical treatment.

compliance to the requirement that dispositions be the least onerous and least restrictive. The Supreme Court of Canada elaborated on Winko in Pinet, and wrote:

In this process of reconciliation, public safety is paramount. However, within the outer boundaries defined by public safety, the liberty interest of an NCR accused should be a major preoccupation of the Review Board when, taking into consideration public safety, the mental condition and other needs of the individual concerned, and his or her potential reintegration into society, it makes its disposition order.26

The Court went on to emphasize the centrality of the then statutory requirement that the disposition and any attached conditions be the “least onerous and least restrictive” option so as to be compliant with the Charter, writing that:

…even where a risk to the public safety is established, the conditions of the disposition order are to be “the least onerous and least restrictive to the accused” consistent with the level of risk posed considering the mental condition of the NCR accused, the objective of eventual reintegartion into the community and his or her other needs.27

In a 2014 decision, the Ontario Review Board (ORB) considered the new language of “necessary and appropriate” and came to the conclusion that the Winko requirement of “least onerous and least restrictive” persists. The ORB found that the language of “necessary and appropriate” still required them to make a disposition that is the least onerous and least restrictive, despite this language no longer appearing in the statute. The Board stated:

As indicated, the amendments to part XXI of the Criminal Code came into effect today. It was the submission of Mr. MacKenzie, supported by counsel for the Attorney General that by using the language "necessary and appropriate" in the current form of s. 672.54, parliament did not intend to change the requirement that the Board's Disposition be "the least onerous and the least restrictive". …We are satisfied whether one uses language of "necessary and appropriate" the Board must make a Disposition that is the least onerous and least restrictive.28

We note that the courts have not interpreted this language and so it is possible a court would view the new language differently. However, given the statements of government officials that the intent of the wording change was to clarify and not eliminate the requirement for “least

26 Pinet v St. Thomas Psychiatric Hospital, 2004 SCC 21, at para 19, 1 SCR 528.
27 Pinet v St. Thomas Psychiatric Hospital, 2004 SCC 21, at para 21, 1 SCR 528 (referencing Tulikorpi).
onerous and least restrictive,” the references to being consistent with Winko, and the interpretation of the Ontario Review Board of the meaning of “necessary and appropriate” it is reasonable to assume that the overarching requirement that dispositions be “necessary and appropriate” would be read by courts and the Review Board in Nova Scotia as consistent with the previous statutory requirement of “least onerous and least restrictive.” It is our opinion, therefore, that the jurisprudence interpreting the phrase “least onerous and least restrictive” continues to apply to dispositions.

The second change explicitly makes public safety the paramount consideration when balancing the factors set out in the section. The previous wording had required consideration of the “need to protect the public from dangerous persons”. As is apparent in the quote from Pinet above, the Supreme Court of Canada has interpreted this public safety factor as paramount among the listed factors. The amendment simply codifies this principle and so does not change the law.

The third change related to section 672.54 that came into effect in July 2014 is the addition of a definition of the existing phrase “significant threat to the safety of the public.” It is defined as “a risk of serious physical or psychological harm to members of the public… resulting from conduct that is criminal in nature but not necessarily violent.”29 The definition draws upon the Supreme Court of Canada’s interpretation in Winko of this phrase.30 This change is thus intended to codify the common law and not to modify it.

Part V of this report addresses the implications of these requirements of the Criminal Code (and associated administrative law principles) for the prospective use of EM as a means of supervising community access. Before moving to that and the other legal analyses undertaken for this report, we turn to certain foundational factual issues (and the state of the information which we were able to locate on these issues) that are of primary relevance to each of the various legal analyses we have conducted in connection with the proposed pilot project.

IV. Background Information: EM as a Tool for Monitoring Forensic Mental Health Patients Exercising Community Access

The following factual issues are of particular relevance to the analysis of EM as a proposed form of monitoring forensic patients exercising community access:

29 Criminal Code, RSC 1985, c C-46, s 672.5401.

30 See the discussion of this phrase in Part IV of this report.
• risk to public safety posed by forensic mental health patients exercising community access while under a hospital detention order;
• effectiveness of EM in reducing risk to public safety; and
• effectiveness of other monitoring methods in reducing risk to public safety.

In this part, we take up each of these issues in turn, in order to lay a factual foundation to inform the various legal questions and analyses that we address in the rest of the report. This foundation reflects the information that we were able to retrieve during the course of our research. New or different information may change the analysis. We attempt not to duplicate this discussion and so will refer back to the below information when appropriate.

A. Risk to Public Safety Posed by Forensic Mental Health Patients Exercising Community Access

1. Significant Threat to the Safety of the Public

Under section 672.54(a) of the Criminal Code, a mentally disordered offender must be granted an absolute discharge if s/he is found not to present “a significant threat to the safety of the public.” Therefore, an individual who is subject to a hospital disposition has been determined by the Review Board to present a “significant threat.” Indeed, individuals subject to a hospital disposition have been deemed unsuitable for an absolute or conditional discharge because they present an undue risk to the public.

The Supreme Court of Canada provided interpretation of the phrase “significant threat” in Winko:

Section 672.54 provides that an NCR accused shall be discharged absolutely if he or she is not a “significant threat to the safety of the public”. To engage these provisions of the Criminal Code, the threat posed must be more than speculative in nature; it must be supported by evidence: D.H. v. British Columbia (Attorney General), [1994] B.C.J. No. 2011 (QL) (C.A.), at para 21. The threat must also be “significant”, both in the sense that there must be a real risk of physical or psychological harm occurring to individuals in the community and in the sense that this potential harm must be serious. A minuscule risk of a grave harm will not suffice. Similarly, a high risk of trivial harm will not meet the threshold. Finally, the conduct or activity creating the harm must be criminal in nature: Chambers v. British Columbia (Attorney General) (1997), 116 C.C.C. (3d) 406 (B.C.C.A.), at p. 413. In short, Part XX.1 can only maintain its authority over an NCR accused where the court or Review Board concludes that the individual poses a significant risk of committing a serious criminal offence. If that finding of significant
risk cannot be made, there is no power in Part XX.1 to maintain restraints on the NCR accused’s liberty.\(^31\) (emphasis added)

As indicated earlier in this report, the new definition of “significant threat to the safety of the public” in section 672.5401 codifies the interpretation set out in *Winko* above as it relates to serious physical or psychological harm.

The meaning of “significant threat” is elaborated upon in an Ontario report, *Assessment, Treatment and Community Reintegration of the Mentally Disordered Offender*, Final Report of the Forensic Mental Health Services Expert Advisory Panel for the Ontario Ministry of Health and Long-Term Care (December 2002):

> Forensic clients represent a significant threat to the safety of the public or else they are discharged absolutely from their Ontario Review Board Disposition. Although some forensic clients have relatively minor criminal pasts, others have criminal histories that include extreme violence and/or sexual violence. Owing to the care and support provided by the mental health system in Ontario, the re-offence rate within the forensic population is relatively low, however, re-offences have occurred, and some have been major.

> Forensic clinicians are charged with the responsibility of designing and implementing risk management strategies that will keep the public safe during the community reintegration phase of a client’s rehabilitation.\(^32\)

The majority in *Winko* mentions, however, that prediction of dangerousness is complex and context-specific, and an imperfect science.\(^33\) The majority notes in particular that “[t]he documented tendency to overestimate dangerousness must also be acknowledged and resisted.”\(^34\)

It further suggests:

> …it is precisely because of this difficulty and context-specificity that Parliament has seen fit to replace the categorical common law approach to the mentally ill accused with a flexible scheme that is capable of taking into account the specific circumstances of the


\(^{33}\) *Winko v British Columbia (Forensic Psychiatric Institute)*, [1999] 2 SCR 625 at paras 56 and 58, SCJ No 31.

\(^{34}\) *Winko v British Columbia (Forensic Psychiatric Institute)*, [1999] 2 SCR 625 at para 58, SCJ No 31.
individual NCR accused. Moreover, although it has allowed courts to make an initial
determination, Parliament has created a system of specialized Review Boards charged
with sensitively evaluating all the relevant factors on an ongoing basis and making, as
best it can, an assessment of whether the NCR accused poses a significant threat to the
safety of the public.\textsuperscript{35} (emphasis added)

As discussed further in Part V of this report, Review Boards have the statutory power to delegate
to hospital authorities decisions about increasing or decreasing restrictions on liberty within the
general parameters set by the Review Board. This may be understood to be a means of
recognizing that risk is not a static or determinate phenomenon. That is, the ability of hospital
authorities to grant or refuse community access and to set the conditions of access based in a
dynamic assessment of risk is arguably an essential component of the contemporary forensic
mental health system. In this way, the imperatives of public safety and individual liberty are
balanced in light of the needs of the individual and the general interest in reintegration.

2. Risk to the Public Specific to Absconding When on Leave

Evidence as to the level of risk to public safety posed by forensic mental health patients
exercising community access, and specifically the risks associated with patients who go AWOL,
is extremely limited. The frequency of patients absconding is difficult to determine from the
literature due to the inconsistent and shifting definitions and measurements of absconding.\textsuperscript{36} Moreover, there does not appear to be any research that effectively correlates incidence of
AWOL with the incidence of violence. However, the information that is available suggests that
forensic mental health patients pose a low risk to public safety when exercising community
access. We note that courts can now designate persons found NCR for “a serious personal injury
offense” as “high-risk accused,” resulting in such individuals being barred from leaving the
hospital unless they are escorted.\textsuperscript{37} This measure is presumably intended to ensure that risks to
public safety are considered at multiple stages.

The mechanisms that have been in place at the ECFH historically for reporting and recording
incidents do not allow for easy acquisition of information about significant events involving
patients. However, in June 2014, the Clinical Director at the ECFH surveyed staff about their
recollections over the last decade. They reported that patients have accessed the community
independently from the hospital on thousands of occasions since 2005, and that the “frequency of
dangerous, violent or criminal incidents involving ECFH patients who are accessing the

\textsuperscript{35} \textit{Winko v British Columbia (Forensic Psychiatric Institute),} [1999] 2 SCR 625 at para 59, SCJ No 31.

\textsuperscript{36} Wilkie et al, “Characteristics and motivations of absconders from forensic mental health services: a
case-control study” (2014) 14:91 BMC Psychiatry at 2.

\textsuperscript{37} \textit{Criminal Code}, RSC 1985, c C-46, s 672.64.
community or AWOL has been very low.”

Staff recalled 7 incidents of violence in the community while patients were exercising community access between 2005-2014:

- Four of these incidents occurred while patients were smoking just off of hospital property and were assaults towards other patients. None of the patients were AWOL. Since April 2013, the ECFH has on-site smoking and has eliminated the one-hour pass which was granted for patients to smoke off of hospital property.
- One incident occurred when a patient was being escorted with staff to a medical appointment.
- Two violent incidents involved patients in the broader community:
  - One incident involved an assault by a patient who was out on an overnight pass. The patient was not AWOL.
  - One incident, by far the most serious, was in 2012. This was the incident that led to murder charges against a patient who was AWOL from a one-hour pass, and was the triggering event for the Joint Review.

In response to this 2012 incident and to the Joint Review, new processes for community access were initiated at ECFH. These processes are outlined in Appendix B and discussed more fully later when we address the effectiveness of other methods of monitoring patients in the community. There are no known violent incidents while patients have been on community access pass since the new processes were implemented. There have been 42 instances of an AWOL between April 2013 - April 2014, although this is based on a new and broader definition of AWOL and so includes, for example, thirteen instances of itinerary violations, including six where the violation was returning to the hospital early.

As part of the new processes, the ECFH implemented a number of tools developed to assist with their assessments of community access decisions for individual patients, including tools to assess a patient’s short-term risk of violence as well as risk of going AWOL. The tools have been used since July 2013 and are described in Appendix C “Safety in Numbers: New Violence Risk Management Tools.” The ECFH states:

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38 Appendix B, Dr. Aileen Brunet, Clinical Director, East Coast Forensic Hospital (19 June 2014) “East Coast Forensic Hospital Process Changes Subsequent to 2012.” Please note that all information in this paragraph is from Dr. Brunet.

39 Appendix B, Dr. Aileen Brunet, Clinical Director, East Coast Forensic Hospital (19 June 2014) “East Coast Forensic Hospital Process Changes Subsequent to 2012.”

40 For a description of the tools, see Appendix B, Dr. Aileen Brunet, Clinical Director, East Coast Forensic Hospital (19 June 2014) “East Coast Forensic Hospital Process Changes Subsequent to 2012.”
There [are] some provisional indications that patients who’ve gone AWOL appear to have slightly higher SCAR [Structured Clinical Guide to AWOL Risk] scores than those who do not; this is an area of ongoing interest and we will continue evaluating the scale. As well, patients who have gone AWOL do not appear to have higher imminent violence risk scores (IRRS) than patients who do not go AWOL…. “41

We note that the instruments are limited in that, while they predict risk of violence, they cannot predict the severity of a potential violent incident.42

There is little evidence of the relationship between absconding and violence from other jurisdictions. However, a study was conducted at a large Toronto hospital which investigated the frequency, timing, and determinants of absconding events among a sample of forensic mental health patients over a 24-month period and compared them to a control group. There were two aspects to the study: a literature review and a case-control study. The authors’ literature review found low rates of violence during absconding.43 In the case-control part of the Toronto study, absconding patients included those who left the facility without permission, as well as those granted community access who failed to return on time. Over the 24-month study period, there were 102 absconding events. No member of the public was harmed and no new criminal charges arose. The study authors indicate that the absence of adverse outcomes suggests “that persons being given privileges (such that a greater opportunity existed for them to abscond) did not present an imminent risk for violence to others or themselves.”44 The authors note that when considering forensic populations in particular, there is often a heightened perception of risk to public safety.45 They found in their study that the “ultimate level of public endangerment posed by those who abscond was low;” but noted that it was important to recognize that many of these

41 Appendix B, Dr. Aileen Brunet, Clinical Director, East Coast Forensic Hospital (19 June 2014) “East Coast Forensic Hospital Process Changes Subsequent to 2012.”

42 Personal communications from Aileen Brunet, Clinical Director, ECFH to Constance MacIntosh, Director, Health Law Institute, May 22, 2014 and August 7, 2014.

43 Wilkie et al, “Characteristics and motivations of absconders from forensic mental health services: a case-control study” (2014) 14:91 BMC Psychiatry at 2. The authors report that “the vast majority of studies report very low base rates of offending behavior and violence towards others occurring during a patient’s absconson (e.g., for violence: 1.6%; 1.4%), including absconders who are forensic patients (2.8%; 3.2%; 4.6%; 4.4%), for all absconding events involving interpersonal violence.” Each of the noted percentages represents findings from other studies that are cited in the study.


patients were “judged to be at elevated risk for future violence.”" They stressed the importance of further research into absconding behaviours and patient characteristics to facilitate accurate assessments of risk prior to granting leave as well as implementing effective risk management interventions.

We note that a pilot GPS project in England, discussed under the next heading of this report, reported that prior to the project “many services have experienced serious outcomes following a patient abscond …” The article did not provide information about the quantity nor the nature of the “serious outcomes.” The article also did not report on whether “serious outcomes” occurred during the pilot project and so these comments are of uncertain value.

The above limited information suggests that forensic mental health patients pose a low probability of harm to public safety when exercising community access. When considering the appropriateness of EM as a condition of community access, the Review Board or hospital will need to consider whether EM is commensurate with this low probability of harm.

B. **Effectiveness of EM in Reducing Risk to Public Safety**

There is little information related to the effectiveness that EM may have in responding to a risk of violence when forensic mental health patients exercise community access.

As stated above, no jurisdiction in Canada is using EM for forensic mental health patients accessing the community; however, several jurisdictions internationally have previously used or are currently using EM in this context. The Netherlands and South London, England have implemented consent-based trial projects. Queensland, Australia brought in legislation allowing for the Director of Mental Health to require monitoring for mental health patients, including forensic mental health patients. The Queensland application of EM appears more consistent with the approaches under consideration in Nova Scotia than are the consent-based models.

The legislation in Queensland has only been in force for one year and has not yet been evaluated. The legislation was controversial, having drawn submissions to government from legal and mental health advocates expressing concern about a number of matters, including calling into question the perceived need for EM, its effectiveness, and its potential anti-therapeutic impact.

A group of forensic psychologists in Queensland stated that instances of AWOL were rare during the previous three years while at the same time there had been thousands of successful

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47 David Hearn, “Tracking patients on leave from a secure setting” (2013) 16:6 Mental Health Practice at 18.
unescorted leaves. They questioned the proportionality of, and necessity for, the legislative changes. They also expressed concern about “possible adverse consequences to a patient’s recovery and mental health as a result of implementing new risk management interventions that have no evidence base for this population.”

The Committee of the Queensland Faculty of Forensic Psychiatry expressed its “strong” opposition to the use of tracking devices. They stated it was their view that, amongst other concerns, the use of tracking devices is unnecessary and ineffective in reducing the risk of reoffending. They stated:

The evidence is that the use of GPS tracking devices is unnecessary and ineffective in decreasing the risk of future violence in mentally ill offenders. Mental illness is an important, but modest risk factor for future community violence, when compared to other factors. Research has shown that persons found of unsound mind reoffend less frequently, commit fewer offences (including fewer violent offences) and reoffend less quickly, when compared to persons not afforded a mental health defence.

The Committee also expressed the view:

The use of GPS tracking devices is counter productive in building therapeutic relationships which foster disclosure by patients, establish trust and hope. This is best promoted by a staged approach to LCT [limited community treatment], which enables a patient's mental health and coping to be tested over time, while gradually affording greater freedom and responsibility. Combined with comprehensive risk assessment, this approach is more reliable than either approach alone.

The Committee went on to note:

The National Standards for Mental Health Services 2010, emphasizes recovery orientated mental health practice including the need for supporting autonomy and empowering

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individuals. This is fundamental to the concept of LCT from the HSIS (sic, high security inpatient unit). That is, an individual begins to take responsibility for the processes of reintegration into the community in a graduated fashion, using the trust and therapeutic alliance established with the treating team. The concept of tracking devices is not consistent with this process. To the contrary their use may undermine recovery principles, therapeutic alliance and ironically exacerbate potential risks of adverse incidents.\(^51\)

In 2010, a two-year pilot project was launched in England for GPS tracking of forensic patients. The stated goal of the study was to improve the safety of patients on leave from a medium secure unit, while at the same time promoting leave and recovery. The project was consent-based and resulted in significant increases to patient leave. The process included a risk assessment and decision to grant leave. If GPS tracking was being considered, the patient was given information and an opportunity to discuss it with family and friends. Individuals assessed as high or medium risk, who would not normally be considered for authorized leave, were required to wear a GPS tracker when leaving the unit. Individuals assessed as low risk were asked to consent to use a tracker. If they declined they followed the traditional gradual progression of leave. Those who consented were “generally granted more leave, more quickly and more frequently because of the added assurance the device gives.”\(^52\) The study reported that GPS “has led to the quick return to the unit on several occasions”\(^53\) when patients abscond. The authors concluded that GPS tracking deterred patients from absconding in the early stages of leave. They concluded that GPS tracking helped to manage risk while at the same time significantly increasing patient access to leave. The report did not address whether the use of the GPS tracking had an effect on violent incidents.

Dr. Alexander Simpson, in his report to the Joint Review,\(^54\) discussed the pilot project in England. He also noted that the clinical population in that project is different from the typical Canadian forensic population and thus the effect of EM may be different. In the England pilot project, Dr. Simpson wrote:


\(^{52}\) David Hearn, “Tracking patients on leave from a secure setting” (2013) 16:6 Mental Health Practice at 20.

\(^{53}\) David Hearn, “Tracking patients on leave from a secure setting” (2013) 16:6 Mental Health Practice at 20.

[The] clinical population includes a significant number of persons transferred from the prison service and a group who are detained for treatment of personality disorder that leads to criminal behaviour. This population differs from a typical Canadian forensic population where the patients are rarely serving prisoners [presumably individuals under criminal conviction and not NCR] and who almost all have a primary serious mental illness. …

Its main use was in the early phases of leave, and in the personality disordered patient group for whom risk may be less dynamic and more enduring. Electronic monitoring was used less frequently with persons with mental illness, and later in the rehabilitation process. Whilst GPS technology use may improve the person’s performance in following rules, it is not clear that this sort of “rule following” encourages the person in the ultimate tasks of forensic rehabilitation. Does the use of such technology improve the person’s long term safety? Does it improve the therapeutic alliance to help the person make the life changes necessary to recover from illness and the effects of their offending? Or does its use appear a physical manifestation of distrust and create distance between the patient and the treatment team? It may allow the person more apparent personal freedom than their clinical progress actually should allow.

It is interesting that the technology is more acceptable to offenders with personality disorders, often persons transferred from prison, than to persons with a serious mental illness who have different needs and expectations of their health professionals. Adoption of the GPS technology may appear appealing, but its costs and effects are not clear, nor is it clear who the persons for whom it may have most benefit.55

The above discussion illustrates that the England pilot project is distinct from the pilot project that is being considered in Nova Scotia in several ways. In particular the subject population is different, and individuals are granted leave who would otherwise have been denied leave due to risk factors. The government ought to bear the distinctions in mind when considering what conclusions about the use of GPS can reasonably be extrapolated from this study.

In the Netherlands, a 2008 pilot study was conducted to investigate whether EM “could contribute to the effectiveness of treatment (expressed in terms of the chance of recidivism).”56


56 I.E Berands, M Vinkelvleugel & B Bijl, Band Met Behandeling: Een onderzoek naar de toegevoegde waarde van Electronic Monitoring aan de behandeling van tbs-gestelden en jongeren met een PIJ-maatregel [Electronic Monitoring and the effectivity of treatment of persons placed under a hospital order and juveniles placed in judicial treatment institutions] (Duivendrecht: WODC, PI Research, 2008) at 95 (“Summary”), Online: <http://www.wodc.nl/onderzoeksdatabase/evaluatie-experimenten-electronic-monitoring.aspx>. Please note that only the summary document has been translated to English. We have
The pilot study involved forensic patients and juvenile offenders who chose to participate on a voluntary basis. The authors of the study noted that the experiences of the individuals “may be different if they are compulsorily fitted with Electronic Monitoring.” The study did not investigate the “extent to which the expected negative and positive effects of Electronic Monitoring actually occur.” The authors suggest that EM could work as a deterrent in relation to undesirable behavior and play a part in a more phased structuring of freedoms. They suggest that EM could result in a reduction in the amount of personal contact between the wearer and the institution during community access. However, they also suggest that EM may create a false sense of security in that it is known where the individual is, but not what he/she is doing. There was a lack of comparison data and so no conclusion could be given in relation to the extent to which more or fewer incidents took place while using EM. Despite that limitation, the authors suggest that EM “seems able to offer added value in relation to generating information about incidents. Furthermore, in a number of situations, people have been able to respond to incidents immediately, which prevents any possible escalation of the incident.” While the study was limited in the ways mentioned, information from the interviews conducted as part of the study is helpful. Treatment providers reported that EM did not serve treatment objectives but it did offer additional support for “achieving objectives of other interventions.” Some participants (5 of 19 patients under hospital order) felt EM supported them in complying with agreements. The authors concluded that “[b]y exercising control on movements and agreements made, this system

not reviewed the full study report as it is published only in Dutch. The translated summary is difficult to interpret at times.


60 Note that ‘treatment’ was identified as ‘expressed in terms of the chance of recidivism’ earlier in the summary. It is unclear whether this meaning was carried throughout the translated summary document. The translated version is difficult to interpret at times.
increases the perceived risk of being caught, as a result of which undesirable behavior will occur less frequently." However, the extent of the positive and negative effects of EM were not investigated in the study, and participation was consensual, making use of tentative findings from this study difficult given the differing nature of the Nova Scotia proposal under consideration. It would be important for the government to consider whether the types of individuals who consent to EM and their motivations may have an impact on the effect of EM as compared to where EM is mandatory.

Correctional Services Canada conducted a pilot project in 2008 involving convicted criminals (not forensic mental health patients) in the community (i.e., parole, work release). A 2009 Correctional Service Canada study noted that staff and offenders had different views about the impact of EM on offender accountability. Staff felt it had a deterrent effect while offenders did not share this view. The study authors noted that the literature was inconclusive on this issue. The study report noted numerous technical problems including false alarms and a tendency to show people to be somewhere they are not. They also indicated that EM may potentially increase workloads for parole officers.

In considering whether EM of forensic mental health patients in the community might enhance public safety in Nova Scotia, it will be important to demonstrate a correlation between the incidence of violence and patients being off of their itinerary or staying out too long, and that EM would facilitate prevention of the violence. We are not aware of data or information indicating such a correlation, and note the concern expressed by psychiatrists in Queensland that it could exacerbate risk due to the effect on therapeutic trust. It is also important to consider what, if any, impact the creation of the “high-risk accused” designation will have on the population who is eligible for community access.

C. Effectiveness of Other Monitoring Methods

Between September 2012 and July 2013, the ECFH developed and implemented changes to their community access policies and procedures aimed at public safety. Some of the key changes include:


Elimination of indirectly supervised community access prior to patients’ initial Review Board hearing. Ending these passes reduces opportunities for AWOLs and ensured that all patients had a formal risk assessment completed prior to decisions being made about community access.

Creation of an in-hospital smoking area for patients - This ended the one-hour off-site passes that patients used to smoke and therefore reduces opportunities to go AWOL.

Increasing the minimum pass to three hours instead of one hour. This requires clinical teams to closely consider the patient’s readiness.

Development of a formal day-of pre-pass mental state assessment of patients. This ensures frontline staff have considered the patient’s mental state shortly before being signed out on pass.

Development of four measurement tools to assist in structured and empirically informed decision-making about patients’ community access.

Establishment of the Community Access Oversight Committee. This Committee provides an additional, objective layer of accountability and review that is external to the clinical team in decisions about patients’ community access.

Providing patients with cell phones for use during indirectly supervised passes. This allows for contact during the pass and can also facilitate a mental status check.

Development of a community monitor position. The community monitor checks on patients’ whereabouts when they are in the community and using an itinerary. This allows for detection of patients not following their itineraries and earlier detection of patients who may be going AWOL.

Automatic suspension of community access for a minimum of 72 hours whenever a patient has been AWOL and development of a process to review the AWOL incident.63

As part of the changes, the ECFH developed new approaches to synthesizing information and to assessing the violence risk review processes. The goals of the revised process were:

- collection of data around day-to-day violence risk variables;
- increased, efficient communication of multiple violence risk variables including past and current offences; and

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63 Appendix B, Dr. Aileen Brunet, Clinical Director, East Coast Forensic Hospital (19 June 2014) “East Coast Forensic Hospital Process Changes Subsequent to 2012.”
• tying community access decisions more closely to violence risk management considerations.  

In determining when and how community access is appropriate for a patient, the clinical team considers the patient’s current status regarding conduct in hospital, mental state, substance use, participation in programming, recent scores on the multiple assessment tools related to violence-risk-related variables as well as the goals and purpose of the community access. The recommendation for community access then proceeds through an oversight committee, the ECFH program leader and the Director of Capital District Health Authority Addictions and Mental Health Program. On the actual day of community access, the patient is assessed by frontline staff before being signed out on the community access pass. When patients begin to have indirectly supervised community access, the current options available for monitoring are:

• itineraries - patients may be required to provide a detailed itinerary of their pass plans, with locations of where they are going and times of arrival and departure. Not adhering to the itinerary without advance notice is considered an AWOL incident;

• community monitors - ECFH staff person who goes out into the community to check on patients as per their itinerary; and

• cell phones - patients either have their own cell phone or are provided one by staff to take on pass in order to call in any changes or issues or to be reached if necessary.  

It is difficult to determine with precision the overall impact of these changes to policies and processes at the ECFH. This is due to a number of factors: the low frequency of violent incidents involving ECFH patients prior to and since the changes; the different nature of mechanisms for reporting and recording incidents in place before the changes; and the change in the definition of AWOL which accompanied the above changes. 

Despite this, the ECFH has reported that it is their “perception that the use of the community monitor and the automatic suspension of community access have had a significant impact on incidents of AWOLs.” Further, a survey of ECFH staff indicated “that it is staff’s belief that

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65 Appendix D, East Coast Forensic Hospital, “ECFH Processes Related to Community Access.”

66 Appendix B, Dr. Aileen Brunet, Clinical Director, East Coast Forensic Hospital (19 June 2014) “East Coast Forensic Hospital Process Changes Subsequent to 2012.”

67 Appendix B, Dr. Aileen Brunet, Clinical Director, East Coast Forensic Hospital (19 June 2014) “East Coast Forensic Hospital Process Changes Subsequent to 2012.”
the new processes have reduced AWOL incidents and have enhanced our rehabilitation processes.”

This perception appears to be consistent with comments of the Joint Review about the purpose of monitoring patients. Specifically, “monitoring helps ensure that patients comply with the terms and itinerary of their leave, and their mental state and behavior are tracked.” The purpose of adding cell phones and pagers as part of the monitoring methods was to provide “more tools to help identify changes in emotional or mental states that could affect risk.” The use of cell phones and the community monitor appear to have enhanced the ability of ECFH to monitor a patient’s mental state and risk level.

Although the incidence of violence in the community by ECFH patients was historically low, it appears that additional tools and procedures implemented last year may have enhanced public safety.

The Toronto study suggests that there are other important factors in reducing absconding events. The authors of the study suggest that improvements in therapeutic communication between patients and clinical teams are helpful in that regard. The England pilot project also noted the need for a risk assessment before deciding whether or not to use a tracker with a patient.

These factors will be important in considering whether there are less restrictive and less onerous means of monitoring a patient than EM that address the level of risk posed and the needs of the patient.

V. *Criminal Code / Administrative Law Analysis*

This section addresses the legal requirements under the *Criminal Code* Mental Disorder provisions as these would apply to a decision to require EM as a condition for accessing leave. It also reviews associated administrative law principles concerning the exercise of statutory discretion (i.e., the requirement that discretion be exercised in a manner that is consistent with “fundamental values”). We consider the possibility that such a condition might be imposed

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68 Appendix B, Dr. Aileen Brunet, Clinical Director, East Coast Forensic Hospital (19 June 2014) “East Coast Forensic Hospital Process Changes Subsequent to 2012.”


either as part of a Review Board disposition or through an exercise of delegated authority on the part of ECFH staff charged with supervising community access. Note that this discussion concentrates on individual decision-making, but a similar analysis would apply at the policy level.

A. **Source of Legal Authority to Require EM in an Individual Case**

Two possible entities could impose the use of EM: the Review Board and the Hospital.

As noted above, the Review Board has ongoing jurisdiction to make and review dispositions -- which include conditions of supervision\(^\text{71}\) -- with respect to individuals detained in hospital under the Mental Disorder provisions of the *Criminal Code*. Discretionary decisions about dispositions as well as associated conditions must take account of the factors stipulated in section 672.54 of the *Criminal Code*.

The Review Board has exclusive authority over restrictions placed on the individual’s liberty, but no authority to order treatment. This lies outside its statutory and constitutional mandate.\(^\text{72}\) Given that the purpose of EM is to monitor compliance with terms restricting liberty, if the use of EM is lawful, the Review Board could impose such a restriction directly on a patient.

It is less clear whether the hospital could impose such a condition on its own initiative. However, it is likely that it may do so through delegated authority, as explained below. The hospital has jurisdiction to direct the treatment of the individual in accordance with provincial health care laws (including applicable laws on consent) and professional judgment of hospital staff.\(^\text{73}\)

\(^{71}\) The Supreme Court in *Tulikorpi* canvasses some of the typical conditions ordered by Review Boards (at para 32):

Apart from hospital selection, there are other conditions routinely considered by Review Boards that also affect the liberty interest having regard to “the need to protect the public from dangerous persons, the mental condition of the accused, the reintegration of the accused into society and the other needs of the accused”. The disposition order may specify that the detainee is (or is not) to have access to the grounds of the hospital, or to the community within a defined radius (including a weekend or overnight pass), and, if so, the level of accompanying supervision, if any. The Review Board may specify the purposes for which community access is authorized (such as medical or dental treatment, education, employment, recreation, or social activities). Equally, the conditions may place particular restrictions on a detainee’s liberty. In a conditional discharge under s. 672.54 (b) for example, such restrictions may include a prohibition against consuming alcohol or drugs, using or possessing firearms, associating with particular persons or classes of persons, and reporting requirements.

\(^{72}\) *Mazzei v British Columbia (Director of Adult Forensic Psychiatric Services)*, 2006 SCC 7 at para 39, 1 SCR 326; *Criminal Code*, RSC 1985, c C-46, s 672.55.

\(^{73}\) *Criminal Code*, RSC 1985, c C-46, s 672.55.
The term “treatment” is not defined in the *Criminal Code*. In the context of the Mental Disorder provisions, courts have stated that treatment “clearly contemplates medical treatment in the form of drugs or therapies recommended, approved, delivered and supervised by hospital staff.” The term “treatment” has not been interpreted broadly in this context, or in a manner that would suggest that EM would be considered a treatment within the exclusive jurisdiction of the hospital. The *Criminal Code* provides authority for the Review Board to delegate aspects of its decision-making powers. Specifically, where the Review Board orders detention in a hospital, it may (under section 672.56 of the *Criminal Code*) delegate to the person in charge of the hospital “authority to direct that the restrictions on the liberty of the [NCR] accused be increased or decreased within any limits and subject to any conditions set out in that disposition ….” The delegated person’s direction is deemed to be a disposition of the Review Board. Section 672.56 further provides that if the delegated person increases restrictions on the liberty of the individual significantly, the person shall make a record of the increased restriction, and where it remains in force for more than 7 days, shall report it to the Review Board which shall then hold a hearing.

There has been little judicial commentary on section 672.56 of the *Criminal Code*. However, courts have commented that the rationale for the delegation is to ensure that Review Board orders are “sufficiently flexible to respond quickly where circumstances warrant a variation of the disposition.” While the Review Board cannot delegate its core responsibility (for instance, its responsibility for making decisions about the applicable *Criminal Code* disposition), it may delegate “certain decisions within the parameters of the Review Board’s “outer envelope” that allows the hospital to respond to changing circumstances.” The delegated authority must be exercised having due regard to the individual’s “liberty interest in light of the twin goals of public safety and treatment, but it permits a degree of day-to-day fine tuning that, if properly exercised, will prevent the ‘least onerous and least restrictive’ requirement from compromising achievement of treatment objectives.”

In Nova Scotia, orders of the Review Board often authorize up to the highest level of community access under the Community Access Policy, without explicitly delegating to the Director of the

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74 Mazzei v British Columbia (Director of Adult Forensic Psychiatric Services), 2006 SCC 7 at para 53, 1 SCR 326.
75 *Criminal Code*, RSC 1985, c C-46, ss 672.56 and 672.81(2.1).
78 *Penetanguishene Mental Health Centre v Ontario (Attorney General)*, 2004 SCC 20 at para 69, 1 SCR 498 [“Tulikorpi”].
Hospital the power to select the methods for determining when a patient is ready for community access, or the methods for monitoring any community access granted. The question is thus whether the Board’s standard practice of referring to a “ceiling” of community access without specific reference to the means of supervising or monitoring access constitutes a delegation of authority that would include the hospital ordering the use of EM.

There is some jurisprudence on implied delegation. In *Wiebe*, the Manitoba Court of Appeal concluded, on a contextual and purposive analysis, that no explicit reference to section 672.56 of the *Criminal Code* was required in order for a Review Board to lawfully delegate authority to increase or decrease limits on liberty within the parameters set by the Review Board. In that case, the Review Board had ordered that the patient could access all areas of the forensic unit, but delegated to the treatment team the power to limit or revoke that privilege on certain conditions (non-compliance with hospital rules or a determination of mental instability). The Court of Appeal determined that omitting to cite section 672.56 was not fatal to the delegation of authority. It stated that to expect Review Boards to make an explicit delegation of authority for every contingency whereby the hospital might seek to adjust conditions of supervision in response to changes in a patient’s circumstances would amount to charging the Review Board with “micromanaging every fluctuation in the patient’s course of treatment …”

What, if any, legal authority grounds the power of hospital staff to require EM as a condition of community access in the absence of a Review Board order explicitly adverting to this decision? The answer depends upon whether a hospital disposition by a Review Board or, more specifically, an order contemplating the highest level of community access appropriate to the patient’s circumstances, necessarily or implicitly confers upon hospital authorities not only the power to make decisions about community access reflecting such considerations as mental condition and risk, but also the power to make decisions about the means of supervising community access such as EM. An implicit delegation of the power to devise and implement means of monitoring patients in the community (where this power is not explicitly accorded in a Review Board order) arguably flows from the fact that supervising or monitoring compliance with the conditions placed on community access is integral to the advancement of the various purposes stated in Part XX.1 of the *Criminal Code*, including public safety, reintegration, and the therapeutic needs of the individual. Our preliminary analysis, then, is that the ECFH’s authority to devise and implement methods for monitoring community access is implicitly conferred upon it as a function of the Review Board’s authority to delegate authority under section 672.56 of the *Criminal Code*. On our understanding, explicit authority to devise systems for granting and monitoring community access need not be conferred on the hospital by the Review Board.

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While there are grounds to argue that an implicit conferral of authority is present, if government wishes to proceed with an EM policy, it may wish to pursue routes for making the conferral of authority to impose EM explicit.

B. Limits on Legal Authority Under Criminal Code and Administrative Law

As indicated above, the Review Board has broad authority to set conditions for a detention order. These include forms of monitoring community access, so long as they meet the Criminal Code requirements of being “necessary and appropriate”, taking into account the risk posed to the public, the mental condition of the accused, his/her treatment needs and other needs, and the objective of reintegration, as well as the requirements that they be least onerous and least restrictive, and that they comply with Charter values. Where the authority to direct an increase or decrease in patient liberty is delegated to the hospital, whether explicitly or implicitly, the hospital must exercise this authority in light of the same factors as inform the discretion of the Review Board.

1. The Statutory Standard in Light of Administrative Law Principles

A decision to require EM as a condition of community access (whether of the Review Board or hospital staff) involves an exercise of statutory authority. It engages not only the terms of the relevant statute (here, the Criminal Code) but also administrative law principles – in particular, principles regarding the exercise of statutory discretion. A decision on the conditions appropriate to a detention order is “discretionary” because it involves weighing a set of factors (public safety, treatment needs, the objective of reintegration) to arrive at a decision. If evaluating a decision, two key questions arise from the perspective of administrative law: 1) What standard of review would be engaged by the decision?; and 2) What legal expectations arise on application of that standard?

a) Applicable Standard of Review

The Mental Disorder provisions of the Criminal Code include a statutorily provided right of appeal that could be drawn upon by a patient who was ordered to use EM:

672.72 (1) Any party may appeal against a disposition made by a court or a Review Board, or a placement decision made by a Review Board, to the court of appeal of the province where the disposition or placement decision was made on any ground of appeal that raises a question of law or fact alone or of mixed law and fact.

This appeal mechanism applies to a decision of the Review Board and possibly to a decision of hospital staff requiring EM. This is because decisions of hospital authorities concerning
conditions of supervision are “deemed” to be decisions of the Review Board. However, it is likely that a decision of the hospital would be most appropriately challenged in the first instance at a Review Board disposition hearing and not at the Court of Appeal.  

The Criminal Code Mental Disorder provisions provide a standard for reviewing a decision. Section 677.78 states:

672.78 (1) The court of appeal may allow an appeal against a disposition or placement decision and set aside an order made by the court or Review Board, where the court of appeal is of the opinion that:

(a) it is unreasonable or cannot be supported by the evidence;

(b) it is based on a wrong decision on a question of law; or

(c) there was a miscarriage of justice.

The legality of a decision to require EM as a condition of community access likely would be reviewed under section 672.78(1)(a). This reflects the nature of the decision, which is an exercise of discretion involving consideration of the facts in light of the requirements of section 672.54.

b) Legal Expectations Under the Standard of Review

The legislative standard stated in section 672.78 of the Criminal Code is a “reasonableness” standard. Under that standard, an exercise of discretion may be deemed unreasonable – and thereby be quashed - where, inter alia, the decision-maker has failed to take account of a legally relevant factor or has taken account of an irrelevant factor, or where the decision cannot be supported by the evidence. In applying this standard, courts must show a level of “deference” to the decision-maker and decision, and must demonstrate respect for the expertise and/or experience of the decision-maker and for the legislature’s intention to vest the administrative decision-maker with authority to make the decision in the first instance. In particular, an expert tribunal’s evidence-based assessment of risk and/or of the effectiveness of a given supervisory condition in reducing risk may attract significant deference from a court on review.

Where a discretionary decision engages Charter values, as here, specific legal expectations arise. In Doré v Barreau du Québec, the Court stated that discretionary decisions engaging Charter values must balance these with statutory objectives in a manner that reflects “proportionality.” The Court used the example of Pinet (which involved a challenge to a Review Board’s decision

83 Criminal Code, RSC 1985, c C-46, s 672.82; R v Runnalls, 2007 ONCA 65, OJ No 300.

84 Suresh v Canada (Minister of Citizenship and Immigration), 2002 SCC 1 at paras 29-32, SCJ No 3.

85 Doré v Barreau du Québec, 2012 SCC 12 at paras 56-57,, 1 SCR 395.
to transfer an NCR inmate from a medium to a maximum security institution) to illustrate how statutory objectives are to be balanced with Charter values in the context of Review Board dispositions:

In Pinet, the twin goals of public safety and fair treatment grounded the assessment of whether an infringement of an individual’s liberty interest was justified.\(^{86}\) Indeed, in Pinet the Court articulated the following as a “principle of fundamental justice” that must guide the exercise of discretion where Review Boards make dispositional decisions:

The principles of fundamental justice require that the liberty interest of individuals, like the appellant, who have been found not criminally responsible (“NCR”) for a criminal offence on account of mental disorder be taken into account at all stages of a Review Board’s consideration. The objective is to reconcile the twin goals of public safety and treatment. In this process of reconciliation, public safety is paramount. However, within the outer boundaries defined by public safety, the liberty interest of an NCR accused should be a major preoccupation of the Review Board when, taking into consideration public safety, the mental condition and other needs of the individual concerned, and his or her potential reintegration into society, it makes its disposition order.\(^{87}\)

The Court restated this expectation in slightly more straightforward terms in stating that decisions about dispositions and associated conditions must be

anchored in the liberty interest of the NCR accused when applying the four factors specified in s. 672.54, namely the safety of the public, the mental condition of the NCR accused, his “other needs”, and his potential reintegration into society.\(^{88}\)

The Court in Doré identifies this reasoning with the broad principle that an exercise of statutory discretion must “balance,” in a manner reflective of proportionality, the statutory mandate and any Charter values engaged by the decision. The primary Charter value engaged by a decision to impose EM as a condition of accessing the community is liberty. However, additional Charter values, including equality (addressed below in our analysis of section 15), may be engaged by and, if so, must be factored into, a decision whether to require EM in an individual case.

In sum, analysis of the legality of EM as a condition of a forensic mental health patient’s accessing the community must take account of the statutorily prescribed factors under section 672.54, and its judicial interpretation in light of the Charter, while also remaining cognizant of

\(^{86}\) Doré v Barreau du Québec, 2012 SCC 12 at para 55, 1 SCR 395.

\(^{87}\) Pinet v St. Thomas Psychiatric Hospital, 2004 SCC 21 at para 19, 1 SCR 528.

\(^{88}\) Pinet v St. Thomas Psychiatric Hospital, 2004 SCC 21 at para 26, 1 SCR 528.
the administrative law principles engaged by the exercise of statutory discretion. In particular, the power to make a disposition must be understood in light of administrative law principles which require review on the standard of reasonableness. Section 672.54 of the Criminal Code already incorporates a requirement to take account of the value of liberty in exercising discretion. Administrative law principles reinforce or amplify this requirement, and additionally support a duty to consider whether other Charter values (such as equality) are dealt with in a manner reflecting proportionality.

C. Application of the Statutory / Administrative Law Standard

In this part, we apply the above legal framework to determine whether a decision to require EM as a condition of accessing the community is likely to be deemed a reasonable exercise of the statutory authority conferred under section 672.54 and/or of the delegated authority whereby hospital staff may adjust conditions of supervision under section 672.56. This analysis requires consideration of the factual issues identified in Part IV, above, with regard to the risk to public safety posed by the patient exercising community access, the likely effect of EM on reducing risk to public safety, and the availability of less restrictive means of reducing or managing risk. We consider the arguments likely to arise under each of the options suggested to us by government: a blanket policy requiring EM of all forensic mental health hospital patients accessing the community; a policy requiring EM based in individualized assessment; and the status quo (no EM required of any patients accessing the community).

1. EM as a Necessary Condition of Community Access (“blanket” policy)

Risk to public safety posed by forensic mental health hospital patients accessing the community

As noted above, only those individuals who have been deemed to present a “significant threat” to public safety may be subject to a hospital disposition, according to section 672.54 and a portion of this population may be prohibited from leaving the hospital without an escort. Of the population which is not designated a “high-risk accused,” the fact that a Review Board has determined (typically, at some point in the prior 12 months) that an individual poses a “significant threat” to the public might be relied upon to justify EM as a condition of community access as a blanket policy. However, recognition that persons subject to a hospital disposition have been determined to present a significant threat is offset by the requirement that hospital authorities monitor individual circumstances (including fluctuations in mental condition and level of risk) on an ongoing basis, in an effort to comply with the “necessary and appropriate” means requirement of the Criminal Code as well as the requirement that it be least onerous and least restrictive. Indeed, according to policies instituted since 2012 at the ECFH, forensic mental
health patients are not granted community access unless they meet criteria on a dynamic assessment of risk.

A blanket application of an EM policy also appears inconsistent with the requirements of the Criminal Code. The Supreme Court in Winko stated:

Part XX.1, properly applied, avoids undue confinement or restrictions on liberty by its emphasis on individual, ongoing assessment and the terms of s. 672.54 mandating the imposition of the least restrictive terms consistent with the circumstances.\(^\text{89}\)

The emphasis on individualized assessment is brought out in another, similar statement from Winko:

. . . Parliament intended to set up an assessment-treatment system that would identify those NCR accused who pose a significant threat to public safety, and treat those accused appropriately while impinging on their liberty rights as minimally as possible, having regard to the particular circumstances of each case.\(^\text{90}\) (emphasis added)

Review Boards and forensic hospitals are required to exercise their discretion in a manner that reflects the individual’s entitlement “to conditions that, viewed in their entirety, are the least onerous and least restrictive of his liberty consistent with public safety, his mental condition and “other needs” and his eventual reintegration into society.”\(^\text{91}\) Section 672.54 of the Criminal Code has been found to require individualized assessment. A blanket policy mandating EM would likely be found to breach the statutory standard, and specifically the Charter value of liberty incorporated into that standard.

2. EM as a Requirement Based in Individualized Risk Assessment v. the Status Quo

Risk

We have concluded that a blanket policy requiring EM as a condition of community access would likely fail the requirements of section 672.54. This is because this approach would lack an individualized assessment of risk at the time of the requested access, for the purpose of informing the decisions of whether to grant leave, and what means of monitoring or supervising community access to impose. Does this mean that EM is consistent with applicable legal standards as long as it is based in an individualized assessment of risk?

\(^{89}\) Winko v British Columbia (Forensic Psychiatric Institute), [1999] 2 SCR 625 at para 91, SCJ No 31.


\(^{91}\) Penetanguishene Mental Health Centre v Ontario (Attorney General), 2004 SCC 20 at para 3, 1 SCR 498 [“Tulikorpi”].
Compared with a blanket policy, an individualized assessment of risk is more likely to be consistent with the expectation that restrictions on liberty be the “necessary and appropriate” as well as least onerous and least restrictive in the circumstances, taking account of the level of risk posed, the mental condition of the individual, his/her treatment needs and other needs, and the objective of reintegration. However, individualized assessment is not in itself dispositive. Rather, one must consider in addition whether the individualized assessment is able to generate information that is of genuine relevance to the decision about the means of monitoring leave. Moreover, even if information may be generated about, for instance, risk of absconding and/or risk of violence (as appears to be the case under current practices of dynamic risk assessment at the ECFH), it is additionally necessary to determine whether EM is likely to reduce that risk, and whether there are alternative means of managing or reducing this risk that are less restrictive than EM.

**EM as a means of reducing risk to the public**

As indicated in Part IV, above, there is little information available about the effectiveness of EM in reducing violent incidents where hospital patients have been granted access to the community. The state of the information in this regard suggests that an order requiring EM as a condition of leave might be quashed on the basis that it “cannot be supported by the evidence” as per section 677.78. In other words, there is arguably an insufficient evidentiary basis on which to conclude that EM is the least restrictive and least onerous means of addressing the risk to public safety posed by an individual who has been granted community access.

In Australia, mental health professionals working in the forensic mental health system questioned the effectiveness of EM and raised the concern that it could have negative effects on the rehabilitation of forensic mental health patients. They argued that the legislation mandating EM was “disproportionate to any real and identifiable risk.”

The program reviews conducted in England and the Netherlands suggest that EM may contribute to impulse control and act as a deterrent for absconding. They also indicate that EM assists with returning an absconding patient to the hospital. However, these studies did not specifically assess whether EM functioned to reduce the risk or incidence of violence. We note, in addition, the consensual nature of those programs, as well as Dr. Simpson’s comments about the differences in the clinical population at ECFH and the population involved in the England project, and the fact that persons were granted leave with the use of EM who would not normally be granted leave due to their risk factors. The government needs to consider whether the findings from these jurisdictions in relation to absconding or reduced absconding are likely to translate to a

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non-consensual program of EM for the population at the ECFH, and moreover, whether they provide any basis for contemplating a reduced risk of violence.

**Less restrictive alternatives**

So far, we have seen that it is an overarching requirement of section 672.54 that the Review Board (or a hospital exercising delegated discretion) take account of the impact on individual liberty of any conditions of supervision imposed on a forensic mental health patient.

The expert commentary from Toronto includes speculation that improvements to therapeutic communication during periods of community access could help to reduce absconding.\(^9^3\) In Australia, it was suggested that EM may itself negatively affect the therapeutic relationship and the prospects for successful reintegration and is therefore an unsuitable alternative to other means of promoting the objectives of both public safety and reintegration.\(^9^4\)

The ECFH indicates that in their view the processes instituted since the incident in 2012 have had positive effects on reducing AWOL incidents while also having a positive effect on rehabilitation.\(^9^5\) Cell phone monitoring and having a community monitor, along with other procedural changes, would appear to be less restrictive and less onerous means of monitoring a patient’s community access than use of EM; both from a physical perspective (e.g., wearing a device) and in terms of potential stigma (to be discussed in more detail later in this report). This, combined with the lack of information about the effectiveness or likely effectiveness of EM in reducing violent incidents, suggests that these enhanced measures would more likely meet the requirements of the *Criminal Code* than would the use of EM.

The information presented in Part IV of this report suggest that the probability of harm posed by patients accessing the community under ECFH policies and practices materializing is low; that there is little or no evidence indicating that EM would reduce the risk to public safety posed by forensic mental health patients accessing the community; and finally, that there are alternative mechanisms for monitoring compliance with community access conditions that are less restrictive and that may be more conducive to advancing the statutory objectives. If this is so, then an order for EM is unlikely to be deemed a reasonable exercise of the Review Board’s

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\(^9^5\) Appendix B, Dr. Aileen Brunet, Clinical Director, East Coast Forensic Hospital (19 June 2014) “East Coast Forensic Hospital Process Changes Subsequent to 2012.”
authority to determine appropriate conditions or the hospital’s delegated authority to increase or decrease restrictions on liberty within the limits of a Review Board disposition.

**D. Conclusion on Criminal Code / Administrative Law Analysis**

Based on the information that we have reviewed, it is arguable that a decision to require EM based on an individualized assessment could be challenged successfully as an unreasonable exercise of the discretion accorded under the *Criminal Code*. It appears that the *status quo* is the least onerous and least restrictive option as well as being the “necessary and appropriate” option consistent with the requirements of the *Criminal Code*, specifically public safety, the individual’s mental condition and other needs, and his/her eventual reintegration into society.

**VI. Relevance of Information Legislation**

The determination of the source of legal authority to require that a patient wears a GPS bracelet will be important in relation to information legislation. Both the *Freedom of Information and Protection of Privacy Act* (FOIPOP) and the *Personal Health Information Act* (PHIA) require that non-consensual collection, use and disclosure be done in accordance with the legislation. We have not done a full review of their application but, in any case, the government must be mindful of where the authority is grounded to collect, use and disclose information from the GPS devices. A number of circumstances are set out in the information legislation allowing for the non-consensual collection, use or disclosure of information, including that it be authorized by law. The expression “by law” has been viewed by Canadian courts as “broad enough to include a decision of a tribunal or person who is authorized to make an order or determination, such that the order or determination would be considered within the scope of the ‘law’ referred to in the phrase ‘permitted or required by law.’” As such, if use of the GPS bracelet is explicitly authorized by the Review Board or implicitly or explicitly delegated to the ECFH, it is likely that the personal information related to the bracelet would satisfy the requirements of information legislation. If the government wishes the authorization to be explicit, the information legislation could be amended so as to reduce potential uncertainty.

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VII. Charter

The Canadian Charter of Rights and Freedoms is part of the constitution of Canada. It therefore has the status of “supreme law,” meaning that any law (or other government action) that is inconsistent with it is invalid. The forms of government action to which the Charter applies include legislation, regulations, and policies. The Charter also applies to actions of private organizations done in furtherance of a specific government program or policy. However, as discussed in Part V, above, where a statutory discretion is exercised in an individual case and engages Charter values, an administrative law analysis (rather than direct application of the Charter) applies.

As we noted at the beginning of this report, our discussion of the Charter builds upon the concept of the liberty interests that may be engaged through a requirement to use EM for forensic mental health patients accessing the community. In this regard, we discuss sections 7 (life, liberty and security of the person), 8 (search and seizure), 9 (cruel and unusual treatment) and 12 (arbitrary detention) of the Charter. We then discuss section 15 which protects against discrimination. We conclude our discussion of the Charter with a review of section 1, which provides an opportunity for government to justify an infringement of a right set out in the Charter.

Each section of the Charter discussed below is reproduced in full in Appendix E.

A. Life, Liberty and Security of Person (Section 7)

Under section 7 of the Charter, everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.⁹⁷ The rights under section 7 extend beyond criminal law. In New Brunswick (Minister of Health and Community Services) v G (J), Chief Justice Lamer stated “s.7 is not limited solely to purely criminal or penal matters. There are other ways in which the government, in the course of the administration of justice, can deprive a person of their s.7 rights to liberty and security of the person, e.g., civil committal to a mental institution.”⁹⁸

The test for establishing a violation of section 7 in relation to the use of EM for forensic mental health patients involves consideration of:

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⁹⁸ New Brunswick (Minister of Health and Community Services) v G (J), [1999] 3 SCR 46 at para 65, SCJ No 47.
(1) whether EM will limit patients’ rights to life, liberty or security of the person; and
(2) whether that potential limitation is in accordance with the principles of fundamental justice.99

While the courts have not considered the constitutionality of EM, they have made instructive comments about EM in the criminal context. The Supreme Court of Canada decisions in Gough100 and other cases101 suggest that if a challenge were to be launched by ECFH patients, there is some reason to believe that a challenge may be viewed favourably by the courts.

In the section 7 analysis, the rights to liberty and security are potentially engaged by a policy regarding the use of EM for forensic mental health patients. Each is addressed in turn.

1. **Liberty Interest**

The liberty interest protected by section 7 includes freedom from physical restraint. Detention of an individual by the state “clearly engages the liberty interests of the detainee and any such detention must be in accordance with the principles of fundamental justice.”102 Liberty is also engaged “where state compulsions or prohibitions affect important and fundamental life choices.”103 The requirement under the Criminal Code to order the “necessary and appropriate” conditions compatible with public safety and the other requirements of the Criminal Code, as well as the requirement that the conditions be least restrictive and least onerous, must be considered when conducting the section 7 analysis of EM for forensic mental health patients.

In Winko v British Columbia,104 the Court held that the possibility of an indeterminate detention did not violate an NCR accused’s section 7 Charter rights because the individual’s liberty was restricted for the purposes of treatment and public safety, not “for the purpose of punishment.”105 Further, although the Court held in Winko that the legislative scheme that addresses NCR accused does not violate section 7, that “ruling does not preclude the finding of a s. 7 violation

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99 *Canada (Attorney General) v PHS Community Services Society*, 2011 SCC 44, 3 SCR 134.

100 *Gough v Canada (National Parole Board)*, [1991] 2 FC 117.

101 See for example, *Sauvé v. Canada (Chief Electoral Officer)*, 2002 SCC 68, 3 SCR 519.


where governmental actions operate to thwart that scheme’s ‘emphasis on providing opportunities to receive appropriate treatment.”  

The types of conditions that the Review Board may order have “inevitable impacts on an accused’s liberty interests.” The Supreme Court of Canada in Tulikorpi stated:

Apart from hospital selection, there are other conditions routinely considered by Review Boards that also affect the liberty interest having regard to "the need to protect the public from dangerous persons, the mental condition of the accused, the reintegration of the accused into society and the other needs of the accused". The disposition order may specify that the detainee is (or is not) to have access to the grounds of the hospital, or to the community within a defined radius (including a weekend or overnight pass), and, if so, the level of accompanying supervision, if any. The Review Board may specify the purposes for which community access is authorized (such as medical or dental treatment, education, employment, recreation, or social activities). Equally, the conditions may place particular restrictions on a detainee's liberty. In a conditional discharge under s. 672.54(b) for example, such restrictions may include a prohibition against consuming alcohol or drugs, using or possessing firearms, associating with particular persons or classes of persons, and reporting requirements.

The physical detention of an individual by the state engages the liberty interest protected by section 7. In Orru v Penetanguishene Mental Health Centre, Mr. Orru had been found NCR and was detained at a maximum security institution. The Ontario Review Board ordered that Orru be transferred to a medium security facility but the facility could not accept the transfer due to a lack of space.

The Court held that the continued holding of Orru at the maximum security facility and the denial to him of the treatment available at the medium security facility deprived him of liberty and security of the person in breach of section 7. The Court emphasized that “[e]ven though he is a person held within an institution, the continuation of holding at a maximum security facility

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106 DJ v Yukon (Review Board), 2000 YTSC 513, YJ No 80 (Yukon Territory Supreme Court) at para 39 citing Winko v British Columbia (Forensic Psychiatric Institute), [1999] 2 SCR 625, SCJ No 31.

107 Gielzecki (Re), [2005] BCRBD No 83 at para 96 (British Columbia Review Board).


110 Orru v Penetanguishene Mental Health Centre, [2004] OJ No 5203, OTC 1161 (Ont Sup Ct Just).
when the Review Board ordered transfer to a medium security institution was an infringement of liberty because he is in a lockdown centre rather than a greater treatment facility.\footnote{Orru v Penetanguishene Mental Health Centre, [2004] OJ No 5203 at para 20, OTC 1161 (Ont Sup Ct Just).}

Specifically, the Court stated:

The continuation of holding Mr. Orru at Penetanguishene is a breach of s. 7 Charter by depriving Mr. Orru of the liberty and security of his person... If he were in Brockville, the doors are unlocked during the day and most persons there are able to travel unsupervised on the grounds and have privileges to go unsupervised within the community. This medium security facility assists in a gradual reintegration into the community to the extent that the twin goals of public safety and treatment permit. It also permits greater access to family, community facilities and outward looking programming along with their therapeutic effect. To continue holding Mr. Orru in Penetanguishene, the Respondent deprives him of an enlarged circumstance in Brockville.\footnote{Orru v Penetanguishene Mental Health Centre, [2004] OJ No 5203 at para 20, OTC 1161 (Ont Sup Ct Just).}

Further, the Court relied on the decision in Tulikorpi to state that “the choice of the type of hospital and the level of security and conditions of detention have a major impact on the liberty interest of the detained person.”\footnote{Orru v Penetanguishene Mental Health Centre, [2004] OJ No 5203 at para 21, OTC 1161 (Ont Sup Ct Just).} The Court also explained that the procedure in section 672.54 of the Criminal Code is “a deliberate move by the Parliament of Canada to advance to a more humane method of handling persons who experience mental health problems.”\footnote{Orru v Penetanguishene Mental Health Centre, [2004] OJ No 5203 at para 21, OTC 1161 (Ont Sup Ct Just).}

In PS v Ontario,\footnote{PS v Ontario, 2013 ONSC 2970, OJ No 2432.} the Ontario Superior Court of Justice distinguished “overall liberty” from “residual liberty.” Overall liberty is necessarily infringed when a forensic mental health patient is detained in custody at a hospital. Residual liberty “may be engaged when a psychiatric patient is detained at a higher level of security than is necessary in light of that person’s risk to society.”\footnote{PS v Ontario, 2013 ONSC 2970 at para 65, OJ No 2432.}

Where a patient is subject to a detention order and conditions at the ECFH under the Mental Disorder provisions of the Criminal Code the patient’s “overall” liberty interests are legitimately
infringed.\textsuperscript{117} However, as noted in \textit{Winko}, “[a]ny law that does this must conform to the principles of fundamental justice pursuant to s. 7 of the \textit{Charter}.”\textsuperscript{118} This is also true of a policy.

An examination of whether EM of ECFH patients specifically infringes “residual” liberty requires consideration of whether it infringes either their physical liberty or their ability to make fundamental life choices. The proposed pilot project involves the additional mandatory condition that patients wear a GPS monitoring device when they access the community. The condition of EM is not intended to expand patient access to the community, but rather it narrows the opportunity for community access. A patient may have been granted community access prior to the pilot project, but after a pilot project commences may only be permitted to do so if he/she wears a monitoring device. This may mean that the patient will not access the community, which can have a negative impact on treatment and rehabilitation.

As was stated by the Court in \textit{R. v. McLeod},\textsuperscript{119} the use of EM is not a “lenient sentence” and it “severely restricts” an individual’s liberty as it involves a “high level of supervision.”\textsuperscript{120} As such, there would be a heightened impact on the liberty interests of a forensic mental health patient who was required to wear EM in the community.

A court would consider these factors in conjunction with the dual purpose of the \textit{Criminal Code} provisions to protect the public and to provide opportunities for treatment and reintegration.\textsuperscript{121} It would be important that consideration be given to whether and how EM addresses the dual purpose for the individual being considered for community access. Based on the background information discussed in Part IV of this report about the risk of violence and the effect of EM and other monitoring methods, it is highly likely that the liberty interest is engaged by requiring EM as a condition for community access, whether for some or all patients. Therefore, the first step of the test for a challenge of section 7 is likely met.

Before considering whether this potential limit on liberty is in accordance with the principles of fundamental justice, we consider whether the proposed EM policy is also open to challenge on the basis of a violation of security of the person.

\textsuperscript{117} \textit{Winko v British Columbia (Forensic Psychiatric Institute)}, [1999] 2 SCR 625 at para 64, SCJ No 31.
\textsuperscript{118} \textit{Winko v British Columbia (Forensic Psychiatric Institute)}, [1999] 2 SCR 625 at para 64, SCJ No 31.
\textsuperscript{119} \textit{R v McLeod}, [1992] SJ No 672, CA No 5711 (Sask CA).
\textsuperscript{120} \textit{R v McLeod}, [1992] SJ No 672 at 18, CA No 5711 (Sask CA).
\textsuperscript{121} \textit{Winko v British Columbia (Forensic Psychiatric Institute)}, [1999] 2 SCR 625 at para 92, SCJ No 31.
2. Security Interest

The right to security of the person protects “both the physical and psychological integrity of the individual.” 122 It includes the right to “make choices concerning one’s own body.” 123 Security of the person includes situations where the state has “taken steps to interfere, through criminal legislation, with personal autonomy and a person’s ability to control his or her own physical or psychological integrity.” 124

In Reference re ss. 193 and 195.1(1)(c) of the Criminal Code, 125 Justice Lamer remarked that “[s]ection 7 is also implicated when the state restricts individuals’ security of the person by interfering with, or removing from them, control over their physical or mental integrity.” 126 There is concern about the stigma that is associated with wearing a GPS device. The issue of stigma is discussed more fully later in this report when we address section 15 (equality) of the Charter. For now, it is sufficient to note that GPS devices are often associated with monitoring sexual offenders and dangerous criminality. 127 If the device is visible, it is possible the individual may be harassed or confronted by members of the public who may associate the device with dangerousness and criminality. If this happened it could place their physical security at risk. We are not aware of physical or verbal confrontations being reported due to the wearing

122 R v Morgentaler, [1988] 1 SCR 30 at 37, SCJ No 1; New Brunswick (Minister of Health and Community Services) v G (J), [1999] 3 SCR 46, SCJ No 47.
123 Rodriguez v British Columbia (Attorney General), [1993] 3 SCR 519, SCJ No 94.
125 Reference re ss. 193 and 195.1(1)(c) of the Criminal Code (Man), [1990] 1 SCR 1123, SCJ No 52.
126 Reference re ss. 193 and 195.1(1)(c) of the Criminal Code (Man), [1990] 1 SCR 1123 at 1177, SCJ No 52.
127 For example, in the United States there has been widespread publicity regarding new laws that authorize lifetime GPS tracking in some states for pedophile abduction/murderers. As a result, the meaning of being “on GPS monitoring” seems to have changed in the public perception. It previously meant that someone had “gotten into a bit of trouble” but “now seems common” for people to assume the offender is dangerous and quite possible a sex offender. See: Marc Renzema, “Evaluative Research on Electronic Monitoring” (2010) available online: <http://rgable.wordpress.com/electronic-monitoring-of-criminal-offenders/>.


GPS tracking has been used in Alberta to monitor individuals with convictions related to domestic abuse. See: Alberta Justice & Solicitor General, News Release, “Funding for domestic violence victims in Red Deer” (7 April 2014) online: <https://albertajsg.wordpress.com/2014/04/07/funding-for-domestic-violence-victims-in-red-deer/>.
of an EM device other than in the Netherlands study in which a youth “was suspended from school after trouble had broken out because the fellow pupils had noticed the Electronic Monitoring system.”

In *Mills v The Queen*, a case involving government delay in bringing robbery charges to trial, the Supreme Court of Canada found that the combination of stigmatization, loss of privacy, and disruption of family life constituted a restriction of security of the person. The Court noted the importance of security of the person and stated:

…security of the person is not restricted to physical integrity; rather, it encompasses protection against “overlong subjection to the vexations and vicissitudes of a pending criminal accusation”… These include stigmatization of the accused, loss of privacy, stress and anxiety resulting from a multitude of factors, including possible disruption of family, social life and work, legal costs, uncertainty as to the outcome and sanction.

With respect to psychological integrity, two requirements must be met in order to trigger psychological security of the person: (1) the psychological harm must “result from actions of the state”; and (2) the psychological prejudice must be serious.

In *Orru v Penetanguishene Mental Health Centre*, a case discussed previously, the court found a violation of both the liberty and the security interest of Mr. Orru as a result of his continued detention at a maximum security institution rather than a medium-security institution. The court’s discussion did not clearly distinguish the liberty and security interest; however, they found “the delay in transferring Mr. Orru to the Health Centre in Brockville has a psychological impact upon the Applicant as he is denied treatment that is available to him there.”

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The psychological harm that patients may experience may include the knowledge that “the eyes of the state are not merely upon them but affixed to them.” This is true regardless of whether or not the device is visible to the public. This potential harm would result from the actions of the state requiring EM before granting community access.

EM may negatively impact patients with certain diagnoses such as paranoia or other forms of psychosis. As will be discussed more fully under the section 15 Charter analysis, EM may also negatively impact the trust relationship between health care providers and patients.

The courts do not offer significant guidance about what constitutes “serious” psychological harm. However, it does appear to require a high threshold. In our estimation, the potential psychological impacts of EM are unlikely to rise to the level of severity that would meet the “serious psychological harm” threshold.

We conclude that liberty is more clearly engaged in the section 7 analysis than is physical or psychological security of the person, although there are arguments in support of the claim that both interests are engaged. We now turn to consideration of whether a potential violation is a limitation that is in accordance with the principles of fundamental justice.

3. **Principles of Fundamental Justice**

The next step is to determine whether the interference or limit is in accordance with the principles of fundamental justice. Assuming a violation of the liberty or security interest could be shown, a court would then consider three key principles of fundamental justice that bear on the analysis of a possible EM pilot project: arbitrariness; overbreadth; and gross disproportionality. A policy which fails to meet any one of these three factors would violate section 7 of the Charter. The law under each of these principles is developing and there remains areas of overlap between all three forms of the analysis. For ease of presentation, we discuss each under separate headings below.

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137 Kobzar v Her Majesty the Queen et al [Indexed as: R v Kobzar], 2012 ONCA 326 at para 50, OJ No 2179.
a) Arbitrariness

Arbitrariness exists where there is no connection between the effect and the object of the law.\textsuperscript{138} The Supreme Court of Canada has stated:

Where the deprivation of the right in question does little or nothing to enhance the state’s interest (whatever it may be), it seems to me that a breach of fundamental justice will be made out, as the individual’s rights will have been deprived for no valid purpose.\textsuperscript{139}

Further, the Court has explained that when considering whether a law’s application is arbitrary, “the first step is to identify the law’s objectives.”\textsuperscript{140} The second step in an arbitrariness analysis is to “identify the relationship between the state interest and the impugned law.”\textsuperscript{141}

For example, in \textit{Morgentaler},\textsuperscript{142} the accused challenged provisions of the \textit{Criminal Code} that required abortions to be approved by a therapeutic abortion committee of a pre-approved hospital. The purpose of the law was cited as protecting women’s health; however, the majority of the Supreme Court of Canada found that the requirement that all therapeutic abortions take place in pre-approved hospitals did not actually contribute to protecting women’s health, and instead caused delays that were detrimental to women’s health. Therefore, the “law violated basic values because the effect of the law actually contravened the objective of the law.”\textsuperscript{143}

In \textit{R v Swain}, a case that prompted the re-drafting of the Mental Disorder provisions in the \textit{Criminal Code}, the detention of all NCR accused was found to be arbitrary because it was based on an overbroad assumption that all such individuals were still dangerous at the time of sentencing.\textsuperscript{144}

In the case of EM, the government’s stated goal is to improve public safety. The level of public safety sought through the use of EM must be consistent with the dual purpose of the Mental Disorder provisions of the \textit{Criminal Code}, specifically public safety consistent with the patient’s liberty and treatment interests.

\textsuperscript{138} \textit{Canada (Attorney General) v Bedford}, 2013 SCC 72, 3 SCR 1101.

\textsuperscript{139} \textit{Rodriguez v British Columbia (Attorney General)}, [1993] 3 SCR 519 at para 147, SCJ No 94. Note in the \textit{Rodriguez} case, the majority found the assisted suicide laws were in accord with the principles of fundamental justice. The issues in this case are under appeal and will be heard by the Supreme Court of Canada in October 2014.

\textsuperscript{140} \textit{Canada (Attorney General) v PHS Community Services Society}, 2011 SCC 44 at para 129, 3 SCR 134.

\textsuperscript{141} \textit{Canada (Attorney General) v PHS Community Services Society}, 2011 SCC 44 at para 130, 3 SCR 134.

\textsuperscript{142} \textit{R v Morgentaler}, [1988] 1 SCR 30, SCJ No 1.

\textsuperscript{143} \textit{Canada (Attorney General) v Bedford}, 2013 SCC 72 at para 98, 3 SCR 1101.

\textsuperscript{144} \textit{R v Swain}, [1991] 1 SCR 933 at 1009, 1011-1013, SCJ No 32.
The second step in the arbitrariness analysis is to consider whether EM of forensic mental health patients would contribute to the government’s interest or objective of increasing public safety consistent with the other requirements of the Criminal Code. This requires consideration of the risk to public safety posed by forensic mental health patients who have not been designated “high-risk accused” and who are granted community access as well as the effectiveness of EM in managing the risk. As indicated in Part IV of this report, it is unclear whether EM would contribute to increasing public safety because the links between being AWOL and acts of violence are unclear. Further, the information at hand does not establish that EM would be effective in managing the risk. While we note that EM in England and the Netherlands was found to act as a deterrent for absconding early in patient recovery, we also note the distinct conditions under which EM was used in those studies. Absent further information about the effect EM would have on increasing public safety, a court may find the use of EM for forensic mental health patients arbitrary because of the lack of connection between the effect and the objective of the policy. However, it is important to note that courts sometimes show deference to governments where there is conflicting social science evidence.\textsuperscript{145}

Ultimately, a determination of arbitrariness will turn on whether the evidence shows that it is reasonable to believe that being AWOL is a public safety issue. The evidence that we have reviewed is unclear on this issue.

b) Overbreadth

Although overbreadth and gross disproportionality are distinct principles, the Supreme Court of Canada has noted that the two are related in that the question for both is whether there is connection between the policy’s broad effect and its objective.\textsuperscript{146}

A principle of fundamental justice is that a law cannot be overbroad. A law that is overbroad goes “too far and interferes with some conduct that bears no connection to its objective.”\textsuperscript{147} The Supreme Court of Canada explained this concept further in \textit{R v Heywood}:\textsuperscript{148}

Overbreadth analysis looks at the means chosen by the state in relation to its purpose. In considering whether a legislative provision is overbroad, a court must ask the question: are those means necessary to achieve the State objective? If the State, in pursuing a legitimate

\begin{itemize}
\item \textsuperscript{145} \textit{McKinney v University of Guelph}, [1990] 3 SCR 229, SCJ No 122.
\item \textsuperscript{146} See for example \textit{R v Khawaja}, 2012 SCC 69, 3 SCR 555 where the SCC declined to decide whether or not overbreadth and gross disproportionality are distinct constitutional doctrines, and instead dealt with the two concepts together in its analysis.
\item \textsuperscript{147} \textit{Canada (Attorney General) v Bedford}, 2013 SCC 72 at para 101, 3 SCR 1101.
\item \textsuperscript{148} \textit{R v Heywood}, [1994] 3 SCR 761, SCJ No 101.
\end{itemize}
objective, uses means which are broader than is necessary to accomplish that objective, the principles of fundamental justice will be violated because the individual's rights will have been limited for no reason. The effect of overbreadth is that in some applications the law is arbitrary or disproportionate.\footnote{R v Heywood, [1994] 3 SCR 761 at 792-793, SCJ No 101.}

In \textit{Winko}, the Court addressed the argument that section 672.54 of the \textit{Criminal Code} was overbroad. Specifically, the Court emphasized:

\begin{quote}
The question is whether the means chosen by the State are broader than necessary to achieve the State objective... The dual objectives of Part XX.1, and s. 672.54 in particular, are to protect the public from the NCR accused who poses a significant threat to public safety while safeguarding the NCR accused's liberty to the maximum extent possible. To accomplish these goals, Parliament has stipulated (on the interpretation of s. 672.54 set out above) that unless it is established that the NCR accused is a significant threat to public safety, he must be discharged absolutely. In cases where such a significant threat is established, Parliament has further stipulated that the least onerous and least restrictive disposition of the accused must be selected. In my view, this scheme is not overbroad. It ensures that the NCR accused's liberty will be trammelled no more than is necessary to protect public safety.\footnote{Winko v British Columbia (Forensic Psychiatric Institute), [1999] 2 SCR 625 at para 70, SCJ No 31.}
\end{quote}

In \textit{R v Demers},\footnote{R v Demers, 2004 SCC 46, 2 SCR 489.} the accused was found to be permanently unfit to stand trial. As a result of certain sections of the \textit{Criminal Code}, the accused remained in the “system” created by Part XX.1 of the \textit{Criminal Code} until he either became fit or until the Crown was unable to prove a \textit{prima facie} case.\footnote{R v Demers, 2004 SCC 46, 2 SCR 489.} The accused argued these provisions infringed his section 7 rights, as he would never be able to stand trial and yet was subjected to indefinite appearances before the Review Board.

The Court held that the provisions did infringe his right to liberty, and that this infringement was not in accordance with the principles of fundamental justice as the legislation was overbroad. Specifically, the Court explained:

\begin{quote}
The least onerous disposition under s. 672.54(a), absolute discharge, is not available to the accused found unfit to stand trial. This is justified in the case of an unfit accused who does not suffer from a permanent mental disorder, and does not overshoot the goals of Part XX.1, particularly the goal of providing individual assessment and opportunities for appropriate treatment... Part XX.1 is not overbroad in the case of temporarily unfit accused, because the means chosen by Parliament significantly advance the goals of
\end{quote}
assessment and treatment, which can result in rendering the accused fit for trial and the goal of protecting the public.

However, in the case of a permanently unfit accused, a trial is not a possibility; therefore, the objective of rendering the accused fit for trial does not apply. The criminal process will never come to an end because the accused will not become fit for trial…

Consequently, the continued subjection of an unfit accused to the criminal process, where there is clear evidence that capacity will never be recovered and there is no evidence of a significant threat to public safety, makes the law overbroad because the means chosen are not the least restrictive of the unfit person's liberty and are not necessary to achieve the state's objective. Accordingly, these sections of the law restrict the liberty of permanently unfit accused "for no reason", to use Cory J.'s words in Heywood, supra, at p. 793.153

The key question to ask is whether the proposed EM pilot project is broader than necessary to accomplish the objective of increasing public safety consistent with the requirements of the Criminal Code. The previous discussion about the evidence indicating that the relationship between absconding and risk to public safety is minimal is relevant to the overbreadth analysis. EM may be overbroad in that it could apply to patients who are assessed as a low probability of committing violence while exercising community access. This is especially true if EM is applied to all ECFH patients who have received a disposition which permits them to access the community, regardless of risk categorization.

A court also would consider whether there are less restrictive options for increasing public safety than the use of EM. This was a key consideration in the overbreadth analysis of the Mental Disorder provisions in the Criminal Code in Winko. The discussion earlier in this report concerning the effectiveness of the monitoring methods implemented at ECFH after 2012 is relevant. As discussed, the government may be required to respond to the argument that the existing measures are sufficient.

In light of the evidence of low probability of harm to public safety when forensic mental health patients abscond, that EM may not help prevent violence, and that recent measures may be effective in increasing public safety, strong arguments could be made that the use of EM for all forensic mental health patients accessing the community is broader than necessary to accomplish the goal of public safety consistent with the requirements of the Criminal Code. It is arguable also that the use of EM based on individualized assessment could be found to be overbroad. However, as in the arbitrariness analysis, much will turn on whether the evidence shows that being AWOL is in and of itself a public safety issue.

153 R v Demers, 2004 SCC 46 at paras 41-43, 2 SCR 489.
c) **Gross Disproportionality**

A law violates the principles of fundamental justice when the effect of the law is grossly disproportionate to the state’s objective.\(^\text{154}\) The Supreme Court of Canada has stated:

> The rule against gross disproportionality only applies in extreme cases where the seriousness of the deprivation is totally out of sync with the objective of the measure. This idea is captured by the hypothetical of a law with the purpose of keeping the streets clean that imposes a sentence of life imprisonment for spitting on the sidewalk. The connection between the draconian impact of the law and its object must be entirely outside the norms accepted in our free and democratic society.\(^\text{155}\)

With respect to an EM policy, the key question on the gross disproportionality test will be whether the seriousness of the potential negative effect of EM on matters such as treatment, rehabilitation and stigma are grossly disproportionate to the objective of public safety. As with the other elements of fundamental justice, the evidence regarding the threat to public safety of AWOL forensic mental health patients will be relevant. The possibility of a blanket policy being found grossly disproportionate is low. It is even less likely that a policy involving an individualized assessment would meet the high threshold of being “totally out of sync” with the goal of public safety and so likely would not be found to be grossly disproportionate.

4. **Conclusion on Section 7 Analysis**

The liberty interest protected by section 7 includes freedom from physical restraint. It is engaged when an individual is detained or where state requirements affect fundamental life choices. The liberty interest must be considered in the context of the *Criminal Code* requirements for the “necessary and appropriate” conditions compatible with public safety and the needs of the patient as well as the jurisprudence requiring the least onerous and least restrictive conditions. Based on the background information we have reviewed regarding the probability of harm and the effect of EM and other monitoring methods, it is likely that the liberty interest is engaged by requiring EM as a condition for community access for some or all patients. It is less clear that a security interest would be engaged, as it is unlikely that the potential physical or psychological impact would rise to the level of severity that would meet the court’s “serious” threshold, although there are arguments that both liberty and security interests are engaged.

With the likely engagement of the liberty interest, the first step of the test for a successful challenge likely would be met. The second step is to determine whether the EM policy is consistent with the principles of fundamental justice, specifically arbitrariness, overbreadth and

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\(^\text{154}\) *Canada (Attorney General) v Bedford*, 2013 SCC 72 at para 103, 3 SCR 1101.

\(^\text{155}\) *Canada (Attorney General) v Bedford*, 2013 SCC 72 at para 120, 3 SCR 1101.
gross disproportionality. A policy which fails to meet any one of these three factors would violate section 7 of the Charter. Arbitrariness and overbreadth require that there be a connection between the government’s goal of public safety consistent with the requirements of the Criminal Code and the impact of the EM policy. There is an arguable case to be made that an EM policy (blanket or individualized) would be arbitrary and overbroad because the links between being AWOL and acts of violence are unclear. However, courts sometimes defer to government decisions where there is conflicting social science evidence. The possibility of a blanket policy being found grossly disproportionate is low. It is even less likely that a policy based in individualized assessment would meet the high threshold for being grossly disproportionate.

It appears that an EM policy (blanket or individualized) is at risk of violating section 7 of the Charter. Much of the analysis, however, will turn on the evidence regarding the risk to public safety, the effectiveness of EM in addressing that risk and the effectiveness of alternative methods for monitoring forensic mental health patients in the community.

B. Search and Seizure (Section 8)

Section 8 of the Charter provides that “[e]veryone has the right to be secure against unreasonable search and seizure.”\(^\text{156}\) It is a “personal right.”\(^\text{157}\) In section 8 claims, an appropriate balance must be struck “between the right to be free of state interference and the legitimate needs of law enforcement.”\(^\text{158}\) A contextual approach is taken to this balancing.\(^\text{159}\) This applies to the information being collected by government in the course of EM.

The right to be “free from examination by the state” is “subject to constitutionally permissible limitations.”\(^\text{160}\) First, not every form of examination conducted by the state will constitute a “search” for constitutional purposes. Only “where those state examinations constitute an intrusion upon some reasonable privacy interest of individuals does the government action in question constitute a “search” within the meaning of section 8.”\(^\text{161}\) Second, even those examinations that constitute a “search” for section 8 purposes are permissible if they are


\(^{158}\) R v Vu, 2013 SCC 60 at para 21, 3 SCR 657.

\(^{159}\) R v Plant, [1993] 3 SCR 281 at 293, SCJ No 97.

\(^{160}\) R v Tessling, 2004 SCC 67 at para 17, 3 SCR 432.

\(^{161}\) R v Tessling, 2004 SCC 67 at para 18, 3 SCR 432.
“reasonable.”\textsuperscript{162} A search will not be unconstitutional if it is authorized by law, the law itself is reasonable, and the search was carried out in a reasonable manner.\textsuperscript{163}

In interpreting whether section 8 has been infringed, Canadian courts are required to consider two key matters:

(1) The claimant’s reasonable expectation of privacy:

   a. Did the claimant have a reasonable expectation of privacy? and
   
   b. If there was a reasonable expectation of privacy, was it violated by state conduct?\textsuperscript{164}

(2) Whether the search/seizure was reasonable. In order for a search and/or seizure to be reasonable the Court must find:

   a. the search must be authorized by law;
   
   b. the law itself must be reasonable; and
   
   c. the search must be carried out in a reasonable manner.\textsuperscript{165}

As will be seen, the analysis of the first step appears fairly conclusive that a forensic mental health patient has a very diminished expectation of privacy when exercising community access. Therefore, we address only this element of section 8 and offer the following guidance.

1. **Reasonable Expectation of Privacy**

The Court in *Hunter v Southam Inc.* established the underlying framework which governs the interpretation and delineation of section 8:

The guarantee of security from *unreasonable* search and seizure only protects a *reasonable* expectation. This limitation on the right guaranteed by s. 8, whether it is expressed negatively as freedom from ‘unreasonable’ search and seizure, or positively as an entitlement to a ‘reasonable’ expectation of privacy, indicates that an assessment must be made as to whether in a particular situation the public’s interest in being left alone by

\textsuperscript{162} *R v Tessling*, 2004 SCC 67 at para 18, 3 SCR 432.

\textsuperscript{163} *Collins v The Queen*, [1987] 1 SCR 265, SCJ No 15.

\textsuperscript{164} *R v Tessling*, 2004 SCC 67, 3 SCR 432.

government must give way to the government’s interest in intruding on the individual’s privacy in order to advance its goals, notably those of law enforcement.\textsuperscript{166}

\section*{a) Does the Claimant Have a Reasonable Expectation of Privacy?}

In determining whether a claimant has a reasonable expectation of privacy, the courts must consider “the totality of the circumstances,”\textsuperscript{167} with particular emphasis on: “(1) the existence of a subjective expectation of privacy; and (2) the objective reasonableness of the expectation.”\textsuperscript{168}

In \textit{R v Plant}, Justice Sopinka discussed the concept of informational privacy:

> In fostering the underlying values of dignity, integrity and autonomy, it is fitting that s. 8 of the \textit{Charter} should seek to protect a biographical core of personal information which individuals in a free and democratic society would wish to maintain and control from dissemination to the state. This would include information which tends to reveal intimate details of the lifestyle and personal choices of the individual.\textsuperscript{169}

Importantly, “not all information an individual may wish to keep confidential necessarily enjoys s. 8 protection.”\textsuperscript{170} It is “only if the … activity invades a reasonable expectation of privacy, that the activity is a search.”\textsuperscript{171} Courts have found that information which tracks movements, as well as audio and video surveillance, can be subject to a reasonable expectation of privacy.\textsuperscript{172} In determining the reasonable expectation of privacy, the courts must consider “the totality of the circumstances,”\textsuperscript{173} with particular emphasis on the existence of a subjective expectation of privacy, and the objective reasonableness of the expectation.

The concept of “reasonable expectation of privacy” provides for a \textit{diminished} expectation of privacy in certain circumstances. There is ample case law indicating that individuals formally placed under arrest\textsuperscript{174} and those serving a criminal sentence or a term of probation following a

\textsuperscript{166} \textit{Hunter v Southam Inc.}, [1984] 2 SCR 145, CanLII 33 at para 25.


\textsuperscript{168} \textit{R v Tessling}, 2004 SCC 67 at para 19, 3 SCR 432.

\textsuperscript{169} \textit{R v Plant}, [1993] 3 SCR 281 at p 293, SCJ No 97.

\textsuperscript{170} \textit{R v Tessling}, 2004 SCC 67 at para 26, 3 SCR 432.

\textsuperscript{171} \textit{R v Tessling}, 2004 SCC 67 at para 18, 3 SCR 432.


\textsuperscript{174} \textit{R v Garcia}, (1992), 72 CCC (3d) 240, JQ no 10 (Que CA).
custodial sentence have a significantly reduced expectation of privacy. In other words, what is ‘reasonable’ to expect in terms of privacy is seriously diminished when one is under criminal sanction.

The diminished expectation of privacy has also been found to apply to forensic mental health patients within the custodial hospital setting. In Mazzei v British Columbia (Director of Adult Forensic Services), the British Columbia Court of Appeal noted that forensic mental health patients maintain a diminished reasonable expectation of privacy. The Court stated:

In my opinion, although an NCR accused person is not a convicted criminal and is subject to a special criminal law regime, the context and circumstances of this case support a finding that Mr. Mazzei has a significantly reduced expectation of privacy.

First, the Review Board has found that Mr. Mazzei poses a threat to public safety, and he is subject to a custodial disposition order. As a result of that order, his liberty and ability to make life choices have been restricted. Second, while there are many differences between a custodial psychiatric hospital and a correctional facility, a custodial hospital, like imprisonment, necessarily entails “surveillance, searching and scrutiny”: see Weatherall, supra at 877. The security of the institution, the hospital staff, the public, and NCR accused persons, require a substantially reduced level of privacy within the custodial hospital setting (emphasis added).

Mr. Mazzei was appealing from two disposition orders of the British Columbia Review Board directing that he be detained in custody subject to a number of conditions. Specifically, he challenged the condition in each order that required him to submit to drug testing. Mr. Mazzei argued that the Review Board did not have statutory authority to impose a condition requiring him to submit to urinalysis, and that the condition infringed his rights under section 8 of the Charter to be secure against unreasonable search and seizure.

The Court held that the wording in the Criminal Code and the case law supported the conclusion that the Review Board has jurisdiction to impose drug monitoring conditions in disposition orders. The Court held that the drug monitoring condition does not prescribe treatment, but rather


176 Mazzei v British Columbia (Director of Adult Forensic Services), 2006 BCCA 321, BCJ No 1410. Note this is a different case than the “Mazzei” previously cited, but the individual involved, Vernon Roy Mazzei, is the same for both cases.

177 Mazzei v British Columbia (Director of Adult Forensic Services), 2006 BCCA 321 at paras 45-46, BCJ No 1410.
“provides a tool for assessing Mr. Mazzei’s risk and for informing any treatment and rehabilitative plan.”\textsuperscript{178}

The Court concluded that as an NCR accused person, he had a significantly reduced expectation of privacy, and that drug monitoring did not constitute an unreasonable search and seizure under section 8 of the Charter.

In Vaughan v Ontario,\textsuperscript{179} the applicant was NCR and detained at the Oak Ridge Division of the Penetanguishene Mental Health Centre (“Oak Ridge”), a provincial institution. Under the Charter, the applicant challenged the absolute smoking ban employed by Oak Ridge. He sought a declaration that his section 8 Charter rights were infringed because he was subjected to an unreasonable and unlawful search for tobacco at the institution.

The respondents relied on case law holding that the reasonable expectation of privacy is substantially reduced in the prison setting. They submitted that although the applicant is “not a prisoner,” the principles governing expectation of privacy in the prison context “should also apply” to Oak Ridge. They further argued that even if section 8 is engaged, the search of the Applicant was reasonable and “necessary to protect the safety of patients and staff by keeping Oak Ridge free from weapons and contraband.”\textsuperscript{180}

Justice Pitt held that the respondents’ approach appeared “reasonable.”\textsuperscript{181} Further, Justice Pitt held that the applicant failed to approach section 8 in the context of a psychiatric facility:

> While the case is not cited by the respondents, in Everingham v Ontario, [1993] OJ No 55, Rosenburg J noted that “Oak Ridge is a dangerous place. The patients who are sent to Oak Ridge for assessment and treatment are those whose behaviour prevents them from being assessed in a less secure environment.” In that case, Rosenburg J considered s. 8 in relation to a policy requiring the presence of staff when patients opened mail. In that case, he found that s. 8 was not contravened, but that even if it was, the policy would be justified. The court noted that “what is a reasonable expectation of privacy depends on the context. In a context where random searches to ensure safety and security are commonplace, the reasonable expectation of privacy is low.”\textsuperscript{182}

\textsuperscript{178} Mazzei v British Columbia (Director of Adult Forensic Services), 2006 BCCA 321 at para 39, BCJ No 1410.

\textsuperscript{179} Vaughan v Ontario, [2003] OJ No 5304, OTC 1127 (Ont Sup Court Justice).

\textsuperscript{180} Vaughan v Ontario, [2003] OJ No 5304 at para 25, OTC 1127 (Ont Sup Court Justice).

\textsuperscript{181} Vaughan v Ontario, [2003] OJ No 5304 at para 26, OTC 1127 (Ont Sup Court Justice).

\textsuperscript{182} Vaughan v Ontario, [2003] OJ No 5304 at para 26, OTC 1127 (Ont Sup Court Justice).
The jurisprudence is clear that forensic mental health patients have significantly diminished privacy interests while inside a custodial institution. We are not aware of a case addressing whether the diminished privacy interest extends to the community when patients are exercising community access. The *Dorfer* case, although in the prison context, is instructive in this regard.

In *R v Dorfer*, the accused argued that his section 8 rights were infringed while in custody when the police obtained his whereabouts (the time and date of his dentist appointment) from prison officials. The accused argued that the “search” began at the moment the prison officials revealed “private information about the dental appointment.” The British Columbia Court of Appeal disagreed:

> In a prison setting the whereabouts of an offender at any given time is information that an inmate should not expect to be confidential; it relates to the proper functioning of the criminal justice system. Information regarding where an inmate is scheduled to be, or intends to be, at any time is not information to which a prisoner has a reasonable expectation of privacy. In short it would be unreasonable for the appellant to expect privacy and confidentiality in the information provided to the police by the prison official. As such, the obtaining of this information without a warrant and without the consent of the prisoner does not constitute an unreasonable search or seizure.

The decision in *Dorfer* suggests that prisoners’ diminished expectation of privacy does in fact apply in every aspect of their life, including when patients leave the ECFH on a community access pass.

It would be difficult to establish that a patient had a reasonable subjective or objective expectation of privacy regarding their movements as would be revealed through the use of EM given the various monitoring methods currently in place at the ECFH for community access. These methods include the community monitor, the use of cell phones, itineraries and log sheets. In addition, community access is granted within the *Criminal Code* regime aimed at public protection and reintegration with the community. As such, it is unlikely that one could reasonably expect that a patient under a detention order would not be subject to monitoring to ensure public safety and treatment goals.

A *Charter* claim under section 8 is unlikely to succeed on the basis of no reasonable expectation of privacy. For this reason, we will not proceed to conduct an analysis of the remaining elements of the section 8 *Charter* considerations.

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C. Detention or Imprisonment (Section 9)

We have not conducted a full review of section 9, but offer the following guidance with respect to the relevant principles that should be considered for an EM policy.

Section 9 of the *Charter* provides that “[e]veryone has the right not to be arbitrarily detained or imprisoned.” An inquiry into the constitutional validity of state action under section 9 requires consideration of:

1. whether the claimant was detained or imprisoned; and
2. whether the detention or imprisonment was arbitrary.

1. Is There a Detention or Imprisonment?

In *R v Grant*, the Supreme Court of Canada defined detention for the purposes of section 9:

> Detention under ss. 9 and 10 of the *Charter* refers to a suspension of the individual’s liberty interest by a significant physical or psychological restraint. Psychological detention is established either where the individual has a legal obligation to comply with the restrictive request or demand, or a reasonable person would conclude by reason of the state conduct that he or she had no choice but to comply.\(^{187}\)

It is clear that forensic mental health patients detained in hospital are under a legal obligation to comply with the conditions set for accessing the community. Thus, the patient is detained and/or imprisoned.

2. Is the Detention Arbitrary?

In *R v Hufsky*, the Supreme Court of Canada stated that a “discretion is arbitrary if there are no criteria, express or implied, which govern its exercise.”\(^{188}\) The standards and criteria that govern a power of detention must be “rationally related to the purpose of the power of detention.”\(^{189}\) The need for tailoring the standards to the individual circumstances and public safety goals, and the need for discretion are important factors in assessing whether a detention is arbitrary.

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\(^{187}\) *R v Grant*, 2009 SCC 32 at para 44, 2 SCR 353.


\(^{189}\) Peter Hogg, *Constitutional Law of Canada* (Toronto: Carswell, 2011) at 49.3(a).
The decision in *R v Kobzar*[^190] is instructive. Mr. Kobzar was found to be NCR for criminal harassment and mischief, and the Ontario Review Board ordered his detention in hospital. Five years later, the Board ordered that he be discharged absolutely. The Crown appealed this order, and pursuant to section 672.75 of the *Criminal Code*, the discharge was automatically suspended while the appeal was determined.

Mr. Kobzar argued that section 672.75 violated section 9 of the *Charter* by “mandating a loss of liberty without any consideration of rational criteria or standards.”[^191] Specifically, the duty to detain was “unqualified by standards whatsoever.”[^192] Section 672.75 was triggered by filing a notice of appeal, and Mr. Kobzar argued the suspension of the discharge was made “without consideration of: (1) the merits of the appeal; (2) the mental condition of the accused; and (3) whether the accused posed any risk to the safety of the public.”[^193] The “total absence of criteria” arguably rendered the law arbitrary.[^194]

The Crown submitted that section 672.75 “relates directly to the paramount objective of Part XX.1 of the *Criminal Code*, namely the protection of the public.”[^195] The Ontario Court of Appeal agreed with Mr. Kobzar, and added that the Crown misinterpreted the legislative goals behind Part XX.1. Specifically, the Court remarked that the “Crown’s understanding of the legislative objective as one that is intended to protect the public from “an NCR accused’s possible dangerousness” completely overlooks the dual objective of the legislation.”[^196]

The Court in *Kobzar* found that section 672.75 violated section 9 of the *Charter* and was not justified under section 1.

Whether an EM policy is found to be arbitrary according to the requirements of a section 9 analysis will depend on how the standards are drafted. A court would ask whether the standards reflect the dual objectives of the *Criminal Code* (i.e., public protection and the needs of the patient). It is likely that a blanket policy that applies to all patients exercising community access would violate section 9. A policy that requires individualized consideration and assessment would be more likely to satisfy the requirements of section 9 in not being arbitrary.

D. Treatment or Punishment (Section 12)

We have not conducted a full review of section 12 but offer the following guidance with respect to the relevant principles that should be considered for an EM policy.

Section 12 of the Charter provides that “[e]veryone has the right not to be subjected to any cruel and unusual treatment or punishment.” An inquiry into the constitutional validity of state action under section 12 requires consideration of:

(1) whether the claimant was subjected to “treatment or punishment”; and

(2) whether the treatment or punishment was “cruel and unusual.”

1. Is an EM Policy “Treatment or Punishment”?

In order to constitute treatment within section 12 of the Charter, a court would require “an exercise of state control over the individual.” It is clear that the requirement for EM when forensic mental health patients access the community would constitute treatment within the meaning of section 12. In section 12, the term “treatment” is broadly interpreted and should not be confused with the concept of medical treatment.

2. Is the Treatment “Cruel and Unusual”?

For a treatment or punishment to meet the standard of “cruel and unusual” a court would ask “whether the punishment prescribed is so excessive as to outrage standards of decency.” In July 2014, the Federal Court considered what factors affect the analysis of whether treatment is cruel and unusual. The court stated:

In determining whether treatment or punishment is “cruel and unusual”, Canadian courts have looked at a number of factors as part of a kind of ‘cost/benefit’ analysis. These factors include whether the treatment goes beyond what is necessary to achieve a legitimate aim, whether there are adequate alternatives, whether the treatment is arbitrary and whether it has a value or social purpose. Other considerations include whether the treatment in question is unacceptable to a large segment of the population, whether it accords with public standards


198 Rodriguez v British Columbia, [1993] 3 SCR 519 at 611-612, SCJ No 94.


200 Canadian Doctors For Refugee Care v Canada (Attorney General), 2014 FC 651, FCJ No 679.
of decency or propriety, whether it shocks the general conscience, and whether it is unusually severe and hence degrading to human dignity and worth… 201

Two types of treatment or punishment have been identified as cruel and unusual: (1) those that are “barbaric in themselves,” such as corporal punishment, and (2) “those that are grossly disproportionate to the offence.” 202 The most likely challenge to an EM policy under section 12 would be on the basis of gross disproportionality and not on the basis of a “barbaric” practice. Similar to the conclusion reached on gross disproportionality under section 7 of the Charter, the possibility of a blanket policy being found grossly disproportionate is low. It is even less likely that an EM policy based in individualized assessment would meet the high standard for gross disproportionality.

E. Equality Rights (Section 15)

Section 15 of the Charter is aimed at “preventing discriminatory distinctions that impact adversely on members of groups identified by the grounds” 203 set out in section 15 (or analogous grounds). One of these grounds is mental disability. The test for establishing a violation involves asking:

1. Does the law create an adverse distinction on the basis of one of the grounds set out in section 15(1) or an analogous ground?
2. Does the law have as its object the amelioration of conditions of disadvantaged individuals or groups such that section 15(2) is engaged? and
3. If section 15(2) is not engaged, does the distinction create a disadvantage by perpetuating a prejudice or stereotyping? 204

If a violation of section 15 is found, the court will then consider whether the violation is justified under section 1 of the Charter.

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201 Canadian Doctors For Refugee Care v Canada (Attorney General), 2014 FC 651 at para 614, FCJ No 679.
202 Peter Hogg, Constitutional Law of Canada (Toronto: Carswell, 2011) at 53.3.
204 R v Kapp, 2008 SCC 41, 2 SCR 483; Quebec (Attorney General) v A, 2013 SCC 5 at para 185, 1 SCR 61; Alberta (Aboriginal Affairs and Northern Development) v Cunningham, 2011 SCC 37, 2 SCR 670.
1. **Does an EM Policy Create an Adverse Distinction on the Basis of Mental Disability?**

The first step is to determine whether an EM policy makes an adverse distinction on the basis of the protected ground of mental disability. Section 15 “does not apply to every distinction, only to differential treatment based upon enumerated or analogous grounds.”\(^{205}\)

In determining whether there is a distinction, the analysis requires “an approach that looks at the full context, including the situation of the claimant group and whether the impact of the impugned law is to perpetuate disadvantage or negative stereotypes about that group.”\(^{206}\) To establish a “distinction” under the first step in the section 15(1) test, the Court has commented:

> The role of comparison at the first step is to establish a “distinction.” Inherent in the word “distinction” is the idea that the claimant is treated differently than others. Comparison is thus engaged, in that the claimant asserts that he or she is denied a benefit that others are granted or carries a burden that others do not, by reason of a personal characteristic that falls within the enumerated or analogous grounds of s. 15(1).

It is unnecessary to pinpoint a particular group that precisely corresponds to the claimant group except for the personal characteristic or characteristics alleged to ground the discrimination. Provided that the claimant establishes a distinction based on one or more enumerated or analogous grounds, the claim should proceed to the second step of the analysis. This provides the flexibility required to accommodate claims based on intersecting grounds of discrimination. It also avoids the problem of eliminating claims at the outset because no precisely corresponding group can be posited.\(^{207}\)

Because there is no requirement to posit a specific comparator group, it is likely that a distinction could be established in the context of the proposed EM pilot project on the basis that the pilot project imposes a restriction and/or burden that falls exclusively on members of an enumerated and protected class; specifically, persons with a mental disability.

Importantly, “it is not necessary for all persons possessing the characteristics identified in the enumerated or analogous ground to be affected by the impugned provision if it disproportionately affects the claimant group on the basis of the ground.”\(^{208}\) The courts have been clear that “[d]ifferential treatment can occur on the basis of an enumerated ground despite the fact that not all persons belonging to the relevant group are equally mistreated.”\(^{209}\)

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\(^{205}\) *Inglis v British Columbia (Minister of Public Safety)*, 2013 BCSC 2309 at para 510, BCJ No 2708.

\(^{206}\) *Withler v Canada (Attorney General)*, 2011 SCC 12 at para 40, 1 SCR 396.


\(^{208}\) *Inglis v British Columbia (Minister of Public Safety)*, 2013 BCSC 2309 at para 560, BCJ No 2708.

\(^{209}\) *Nova Scotia (Workers’ Compensation Board) v Martin*, 2003 SCC 54 at para 76, 2 SCR 504.
Therefore, it is not necessary for all persons possessing a mental disability to be affected by the proposed EM pilot project for the project to be considered discriminatory.

Arguably, if the government employs EM, they will create a distinction (those subject to EM) based on the enumerated ground of mental disability – and therefore the first step of the section 15(1) analysis is met.

2. Does the Law Have as Its Object the Amelioration of Conditions of Disadvantaged Individuals or Groups Such That Section 15(2) Is Engaged?

If a court finds the EM policy creates an adverse distinction on the basis of mental disability, the government has the opportunity to establish that section 15(2) applies, which is a complete answer to a section 15(1) claim. 210 Section 15(2) protects distinctions drawn on enumerated or analogous grounds that have as their object the amelioration of conditions of disadvantaged individuals or groups. 211

As we understand it, the purpose of using EM in the proposed pilot project is to achieve the goal of public protection. It is not intended to increase forensic mental health patients’ community access. As such, it is unlikely that the government could successfully argue that the pilot project is aimed at ameliorating the condition of disadvantaged individuals or groups. Further, the Court has stated that laws designed to restrict (or alternatively, punish) behaviour do not qualify for section 15(2) protection. 212 It would appear that the EM policy could be construed as restricting behaviour by preventing patients who otherwise would have been eligible for community access from obtaining community access unless they agree to wear a GPS device.

As it appears that there is no ameliorative purpose behind the EM pilot project, section 15(2) would not apply. The “analysis returns to section 15(1) to determine whether the distinction constitutes substantive discrimination by perpetuating disadvantage or prejudice or by inappropriately stereotyping the excluded group.” 213

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211 R v Kapp, 2008 SCC 41 at para 54, 2 SCR 483.
212 R v Kapp, 2008 SCC 41, 2 SCR 483.
3. Does the Distinction Create a Disadvantage by Perpetuating Prejudice or Stereotyping?

The claimant bears the burden on a balance of probabilities to establish that the differential treatment is discrimination either on the basis of perpetuation of prejudice or stereotyping.

a) Does the Discriminatory Effect of EM of ECFH Patients Perpetuate Prejudice?

In considering whether the discriminatory effect of EM of ECFH patients is the perpetuation of prejudice, a court would consider whether ECFH patients are subject to a pre-existing disadvantage, and the nature of the interest that is affected.214

Pre-existing disadvantage is explained in the Law case, where the Court stated:

As has been consistently recognized throughout this Court’s jurisprudence, probably the most compelling factor favouring a conclusion that differential treatment imposed by legislation is truly discriminatory will be, where it exists, pre-existing disadvantage, vulnerability, stereotyping or prejudice experienced by the individual or group… These factors are relevant because, to the extent that the claimant is already subject to unfair circumstances or treatment in society by virtue of personal characteristics or circumstances, persons like him or her have often not been given equal concern, respect, and consideration. It is logical to conclude that, in most cases, further differential treatment will contribute to the perpetuation or promotion of their unfair social characterization, and will have a more severe impact upon them, since they are already vulnerable.215

The differential treatment of ECFH patients on EM may be discriminatory because it does not have regard to the societal disadvantage and prejudice suffered by mentally ill forensic patients by virtue of their mental disability. As was discussed in Parts III and IV of this report, persons with mental illness have been subject to pre-existing disadvantage, vulnerability, and stereotyping because they have, throughout time, been perceived as “quasi-criminal” and “always dangerous,” a view the courts have stated “we now know to be largely unfounded.”216 The previous criminal laws reflected this perception as they “treated people who had committed no crime and indeed were not capable of criminal responsibility worse than true criminals.”217

In addition to the pre-existing prejudice experienced by the mentally ill, mental health professionals have expressed concern that forensic mental health patients suffer further stigma by virtue of their mentally ill status and their contact with the law.\footnote{Wilkie \textit{et al}, “Characteristics and motivations of absconders from forensic mental health services: a case-control study” (2014) 14:91 BMC Psychiatry; Queensland, Australia, Parliament, \textit{Health and Community Services Committee: Queensland Mental Health Commission Bill 2012}, Submission 16 (5 February 2013) online: <http://www.parliament.qld.gov.au/documents/tableOffice/CommSubs/2013/QldMtlHlthComBill2012/016.pdf> at 8 (submitted on behalf of Dr. Rebekah Doley \textit{et al}).}

In considering whether the discriminatory effect of EM of ECFH patients is the perpetuation of disadvantage or prejudice, a court would examine the nature of the interest that is affected. The nature of the interest is explained in the \textit{Law} decision:

A further contextual factor which may be relevant in appropriate cases in determining whether the claimant’s dignity has been violated will be the nature and scope of the interest affected by the legislation…\footnote{\textit{Law v. Canada (Minister of Employment and Immigration)\textsuperscript{*}}, [1999] 1 S.C.R. 497 at para 74, SCJ No 12.}

Arguably, the nature of the interests affected is significant. The interests at stake are fundamental to “the rights of individual forensic psychiatric patients who have been found not criminally responsible on account of mental disorder to get better and reintegrate with the community.”\footnote{Nova Scotia, Department of Health and Wellness, Department of Justice & Capital District Health Authority, \textit{Joint Review of the East Coast Forensic Hospital’s Community Access Privileges}, (Nova Scotia: 2012) online: <http://novascotia.ca/just/ECFH_Review/Joint-Review.pdf> at 2.} The importance of these interests is reflected in the case law, and the history and purpose of Part XX.1 of the \textit{Criminal Code}. In assessing the use of EM for patients at the ECFH, the government needs to be attentive to the public’s perception of GPS bracelets and how they are used in Nova Scotia and in other jurisdictions. They are used to monitor some individuals convicted of crimes who are in the community.\footnote{See for example Nova Scotia, Department of Justice, \textit{Electronic Supervision}, online: Department of Justice <http://novascotia.ca/just/Corrections/electronic_supervision.asp>; Saskatchewan, Ministry of Justice, \textit{Electronic Monitoring/Intensive Supervision}, online: Ministry of Justice <http://www.justice.gov.sk.ca/cp-electronicmonitoring>; British Columbia, Ministry of Justice, Electronic Monitoring, online: Ministry of Justice <https://www.google.ca/?gws_rd=ssl#q=bc+corrections+electronic-monitoring>.} They are often associated with monitoring sexual offenders.\footnote{For example, in the United States there has been widespread publicity regarding new laws that authorize lifetime GPS tracking in some states for pedophile abduction/murderers. As a result, the meaning of being “on GPS monitoring” seems to have changed in the public perception. It previously} In Alberta, GPS
has been used to monitor individuals with convictions related to domestic abuse. Forensic psychologists in Queensland expressed concern about the stigmatizing effect of such associations. In relation to the association with sexual offenders, they stated:

The suggestion of similar level of risk for those with mental illness is stigmatizing, and does not recognize reduction of risk with effective treatment, or the essential principle of recovery. Nor does it recognize that many patients placed on Forensic Orders have not committed offences of a serious violent nature. Rather it suggests to the general public that mental illness is something to be scared of. Further being made to wear such a device renders patients potentially identifiable as ‘dangerous’ by members of the public. Individuals under the DPSOA [Dangerous Prisoner Sexual Offender Act] have been through a stringent process to assess their risk and eligibility criteria. The proposed process for patients is not at all comparable and as such may impinge on patient rights.

People with mental disability have historically suffered stigma. Individuals in the forensic psychiatric system suffer further stigmatization. It would appear that a solid argument could be made that applying EM to forensic mental health patients will perpetuate disadvantage and exacerbate the stigma they already experience.

b) Is the Discriminatory Effect of EM of ECFH Patients Based on Stereotyped Views?

The second way of establishing that the differential treatment is discrimination is on the basis of stereotyping. A court would consider whether there is correspondence between the policy and the claimants’ needs, capacities and circumstances.

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To establish discrimination by way of stereotyping, the claimant must establish that the EM pilot project reflects the stereotypical application of a presumed group or personal characteristic and that it fails to take into account the needs, capacities, and circumstances of the affected group. The historical prejudice experienced by forensic mental health patients was discussed in Part III of this report. To avoid a finding of discrimination based on stereotyping, the government needs to demonstrate that the pilot project takes into account the needs, capacities and circumstances of patients exercising community access.

If the pilot project requires all patients to use EM, it will be very difficult to demonstrate that the individual’s needs, capacities and circumstances are considered, and thus stereotyping would be found.

If the pilot project relies on the use of individualized assessments and testing, a stronger argument could be made that the project is not based on stereotyping. However, the individual assessments need to be considered in the context of the information related to the probability of a harm materializing. As was discussed in Part IV of this report, the information suggests a low probability of harm materializing. As we understand the information available, it is not clear that EM would reduce the probability of the harm materializing. However, there is little to no information on the magnitude of harm should it materialize. It should be noted that the Supreme Court of Canada has indicated that the magnitude of the harm needs to be balanced as against its probability. 227 We note that there was a single horrific incident in 2012, resulting in second-degree murder charges being laid against a forensic mental health patient. Consideration should be given to whether the changes to the Criminal Code, as well as those already made to the decision-making process for granting community access at the ECFH, and the enhanced monitoring mechanisms adopted, are effective. It is our understanding that a patient at the ECFH who is deemed to present an imminent risk for committing violence would not be eligible for community access and that this assessment is more robust now than it was prior to 2012.

The impact that EM may have on treatment may also be relevant to a court’s consideration of whether the policy takes account of the needs, capacities and circumstances of the patients. As was discussed earlier in this report, some mental health professionals have expressed concern that EM is not responsive to individual needs which is contrary to “sound mental health treatment.” 228 Concern was also expressed that EM may be harmful to the therapeutic relationship, particularly the effect on therapeutic trust, and “ironically exacerbate potential risks

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of adverse incidents.” The Netherlands study noted that EM could send a “double message about the reliability of the individual (you can be trusted and you may take leave v. you cannot be trusted and we are monitoring you whilst you are on leave).” Consideration needs to be given to the therapeutic impact EM may have on the patients at the ECFH.

If a blanket policy is employed, it is likely that stereotyping would be found. If an individualized assessment is used, it is likely that the project would be found not to be based on stereotyping as long as the assessment sufficiently takes into account the needs, capacities and circumstances of the individual.

4. Conclusion on Section 15

It is likely that a law or policy requiring EM for some or all forensic mental health patients exercising community access likely would be deemed “discriminatory” under section 15. A distinction is likely to be established that an EM policy, either a blanket policy or one based on individualized assessment, creates a restriction or a burden that falls exclusively on a protected class – specifically persons with mental disability. The application of EM to some or all forensic mental health patients would likely be held to perpetuate prejudice and exacerbate the stigma this population already experiences. A blanket policy likely would be held to be based on stereotyped views. If there is an individualized assessment, it is unclear that this would be held to be based on stereotyped views because (depending on the nature of the assessment) it may be deemed to take into account the needs, capacities and circumstances of the patient. Assuming for the moment that discrimination is found, we turn to consideration of whether the infringement is justified under section 1 of the Charter.

F. Guarantee of Rights and Freedoms (Section 1)

If a claim of discrimination is made out, the government then has the opportunity, under section 1 of the Charter, to demonstrate that the infringement is a “reasonable limit prescribed by law” that is “demonstrably justified in a free and democratic society.” We discuss section 1 in the context of section 15, but we note that section 1 applies to all Charter rights.

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To establish that its action is justified, the government bears the onus of addressing satisfactorily all of the following questions:

(1) Is the limit prescribed by law?
(2) Is the purpose for which the limit is imposed pressing and substantial?
(3) Are the means by which the legislative purpose is furthered proportionate? and
   (a) Is the limit rationally connected to the purpose?
   (b) Does the limit minimally impair the Charter right?
   (c) Is the law proportionate in its effect?\(^{231}\)

1. Is the Limit Prescribed by Law?

The pilot project would be “prescribed by law” under section 1 if the government enacts or relies on legislation, regulations or policies to implement EM.\(^{232}\) This step of the section 1 analysis likely would be easily met either due to the enactment of new legislation or the existing Mental Disorder provisions of the *Criminal Code*.

2. Is the Purpose for Which the Limit Is Imposed Pressing and Substantial?

The government’s stated goal of EM of ECFH patients is to improve public safety.

Improving public safety likely would be viewed as a “pressing and substantial” purpose for implementing EM.

3. Are the Means by Which the Legislative Purpose Is Furthered Proportionate?

There are three parts to this question, as follows:

a) Is the Limit Rationally Connected to the Purpose?

In *Alberta v Hutterian Brethren of Wilson Colony*, Chief Justice MacLachlin described the rational connection requirement in section 1 as follows:

> To establish a rational connection, the government “must show a causal connection between the infringement and the benefit sought on the basis of reason or logic”: *RJR MacDonald Inc v Canada (Attorney General)*, [1995] 3 SCR 199 at para 153. The

\(^{231}\) *Alberta v Hutterian Brethren of Wilson Colony*, 2009 SCC 37 at para 27, 2 SCR 567.

\(^{232}\) *Irwin Toy Ltd v Quebec (Attorney General)*, [1989] 1 SCR 927 at 981, SCJ No 36.
rational connection requirement is aimed at preventing limits being imposed on rights arbitrarily. The government must show that it is reasonable to suppose that the limit may further the goal, not that it will do so.\textsuperscript{233}

The government must therefore demonstrate that the EM of ECFH patients is “rationally connected” to the goal of increasing public safety (i.e., that it is reasonable to assume that EM will reduce the risk of harm to the public). In particular, the government will have to show it is reasonable to assume that ECFH patients who abscond are a threat to public safety and using EM will reduce the risk.

The literature suggests that the “base rate of offending behavior and violence towards others occurring during a patient’s absconion” is low.\textsuperscript{234} Furthermore, over the past 10 years, the frequency of dangerous or violent incidents involving ECFH patients in the community has been low. The incident in 2012 that led to murder charges is the only known occurrence of violence in the community involving a patient who was AWOL. All other acts of violence that could be recalled by staff at the ECFH occurred when a patient was not AWOL.

Based on this and other information discussed earlier in this report, regarding low rates of violence while patients are AWOL, it could be argued that the connection between the use of EM and reduced rates of violence while AWOL is not made out. However, the courts show a level of deference to government decisions when making determinations about the rational connection element under section 1.\textsuperscript{235} The government may be able to argue that being able to locate patients, even if just a few patients, who are AWOL provides the ability to pick them up before an opportunity presents for violence to occur. Assuming that the government satisfies the rational connection test, we now turn to whether the EM policy minimally impairs the Charter right.

\textbf{b) Does the Limit Minimally Impair the Charter Right?}

In \textit{Alberta v Hutterian Brethren of Wilson Colony}, Chief Justice MacLachlin described the minimal impairment requirement in section 1:

The question at this stage of the s. 1 proportionality analysis is whether the limit on the right is reasonably tailored to the pressing and substantial goal put forward to justify the limit. Another way of putting this question is to ask whether there are less harmful means

\textsuperscript{233} \textit{Alberta v Hutterian Brethren of Wilson Colony}, 2009 SCC 37 at para 48, 2 SCR 567.

\textsuperscript{234} Wilkie et al, “Characteristics and motivations of absconders from forensic mental health services: a case-control study” (2014) 14:91 BMC Psychiatry at 2.

\textsuperscript{235} \textit{Alberta v Hutterian Brethren of Wilson Colony}, 2009 SCC 37, 2 SCR 567.
of achieving the legislative goal. In making this assessment, the courts accord the legislature a measure of deference, particularly on complex social issues where the legislature may be better positioned than the courts to choose among a range of alternatives.\textsuperscript{236}

Although the courts accord governments a measure of deference in looking to see if the measure ‘falls within a range of reasonable alternatives’ a court would consider whether there are less harmful means of achieving the goal of improving public safety than implementing EM.\textsuperscript{237}

As discussed in Part IV of this report, changes were made to the policies and procedures at the ECFH in 2012-2013 to address public safety issues. Elements of the changes related to public safety are outlined in Appendix B. We note the key elements of the elimination of community access prior to a Review Board hearing, the addition of the use of community monitors, smoking facilities in the hospital, the minimum leave being increased to 3 hours which has increased the threshold for community access being granted, and the new tools and processes for assessing community access. We also understand that data is being collected systematically and beginning to be used to help understand predictors of AWOL.\textsuperscript{238}

While it is difficult to compare pre-2012 data with post-2012 data, the staff at the ECFH believes the new processes are effective in addressing public safety concerns and rehabilitation. In particular, the use of the community monitor and automatic suspensions of community access upon being late or varying from the agreed upon itinerary have had “a significant impact on incidents of AWOL.”\textsuperscript{239} It is possible that a court may view the 2012-2013 changes as less intrusive means of monitoring patients in the community that are effective in addressing public safety concerns consistent with the other requirements of the \textit{Criminal Code}. It is unclear whether adding EM to the recently implemented measures will augment achieving the goal of improving public safety.

Based on the information that we have reviewed about the effectiveness of measures currently in place to monitor forensic mental health patients in the community, and the low level of risk that appears to exist, it is our conclusion that there are strong arguments that EM would not minimally impair a forensic mental health patient’s section 15 rights, and so would violate the Charter and not be shielded by section 1. That said, courts sometimes show deference to

\textsuperscript{236} \textit{Alberta v Hutterian Brethren of Wilson Colony}, 2009 SCC 37 at para 53, 2 SCR 567.

\textsuperscript{237} \textit{RJR MacDonald Inc. v Canada (Attorney General)}, [1995] 3 SCR 199 at para 160, SCJ No 68.

\textsuperscript{238} Appendix B, Dr. Aileen Brunet, Clinical Director, East Coast Forensic Hospital (19 June 2014) “East Coast Forensic Hospital Process Changes Subsequent to 2012.”

\textsuperscript{239} Appendix B, Dr. Aileen Brunet, Clinical Director, East Coast Forensic Hospital (19 June 2014) “East Coast Forensic Hospital Process Changes Subsequent to 2012.”
governments dealing with complex social issues\textsuperscript{240} and situations where there is conflicting social science evidence.\textsuperscript{241}

c) Is the Law Proportionate in Its Effect?

If an EM policy were found to meet the minimal impairment requirement, a court would consider the proportionality of beneficial and harmful effects. This stage requires a court to ask “whether the benefits of the impugned [law] are worth the costs of the infringement.”\textsuperscript{242} In other words, when one balances the harm done to the patients’ section 15 right to equality against the benefits associated with the EM of ECFH patients, is the limit on the equality right proportionate in effect to the public benefit conferred by the limit?

In \textit{Oakes}, Chief Justice Dickson explained the purpose of this final step of the proportionality analysis:

\begin{quote}
Some limits on rights and freedoms protected by the \textit{Charter} will be more serious than others in terms of the nature of the right or freedom violated, the extent of the violation, and the degree to which the measures which impose the limit trench upon the integral principles of a free and democratic society. Even if an objective is of sufficient importance, and the first two elements of the proportionality test are satisfied, it is still possible that, because of the severity of the deleterious effects of a measure on individuals or groups, the measure will not be justified by the purposes it is intended to serve. The more severe the deleterious effects of a measure, the more important the objective must be if the measure is to be reasonable and demonstrably justified in a free and democratic society.\textsuperscript{243}
\end{quote}

First, the proportionality analysis requires consideration of the benefits or “salutary effects associated with the legislative goal.”\textsuperscript{244} Improving public safety and preventing incidents of violence is clearly a laudable goal. If EM of ECFH patients assists in recovering AWOL patients sooner, and this early recovery is associated with intervening before violence occurs, this could weigh heavily in a proportionality analysis. As discussed earlier, the literature that we have reviewed does not appear to indicate a clear correlation between violence and being AWOL.

\textsuperscript{240} \textit{Alberta v Hutterian Brethren of Wilson Colony}, 2009 SCC 37 at para 53, 2 SCR 567.
\textsuperscript{241} \textit{McKinney v University of Guelph}, [1990] 3 SCR 229, SCJ No 122.
\textsuperscript{242} \textit{Inglis v British Columbia (Minister of Public Safety)}, 2013 BCSC 2309 at para 631, BCJ No 2708.
\textsuperscript{243} \textit{R v Oakes}, [1986] 1 SCR 103 at 139-140, SCJ No 7.
\textsuperscript{244} \textit{Alberta v Hutterian Brethren of Wilson Colony}, 2009 SCC 37 at para 80, 2 SCR 567.
Second, the proportionality analysis requires consideration of the deleterious effects of EM on ECFH patients’ right to equality under section 15 of the *Charter*. The possible effects of EM on increasing stigma of mentally ill and specifically forensic mental health patients was discussed earlier in the section 15 analysis. In addition, staff at ECFH identified self-stigmatization as a possible effect on patients required to use EM when exercising community access. These concerns would be relevant to the proportionality analysis. We also note that the Joint Review found that the policies and procedures at ECFH met or exceeded standards in place in other Canadian jurisdictions and that gaps identified have been filled. The fact that no other Canadian jurisdiction uses, or is contemplating use of, EM for forensic mental health patients would also likely be a consideration in assessing the proportionality of the use of EM in the proposed circumstances.

Based on the above, we conclude that there are strong arguments that the benefits of EM (assuming that any benefits are demonstrable) are likely outweighed by harms to the equality interests of forensic mental health patients, and so it may be found to meet the proportionality test.

4. **Conclusion on Section 1**

In conclusion, it appears that under the section 1 analysis, a pressing and substantial purpose could be established by government. However, the government would face challenges under the proportionality stage of the test that includes the elements of rational connection, minimal impairment and proportionality. We note that if the government fails to make out any one of these elements, the policy would not be shielded by section 1 and would be found to violate the *Charter*. That said, we note that the courts sometimes show a level of deference to governments making complex social decisions.

Based on the information we have reviewed with respect to the low rates of violence for AWOL patients and whether EM would be an effective way of managing risk of violence, it is arguable that the rational connection test would not be met. With respect to whether an EM policy would minimally impair a forensic mental health patient’s *Charter* rights, the impact of the recently implemented changes at the ECFH will need to be assessed. It is arguable that they may be viewed as less intrusive means of monitoring patients in the community than EM, that are effective in addressing the dual goals under the *Criminal Code* of public safety and patient needs. When considering whether the effects of an EM policy are proportionate to the goal of improving public safety, the key issue will be whether the likely salutary effects (in terms of enhancing public safety) are outweighed by the likely effects on the *Charter* interests engaged; including the prospect of increased stigma experienced by forensic mental health patients.

We suggest that if a violation of the *Charter* is established, it may be challenging for the government to demonstrably justify its policy under section 1.
VIII. Human Rights Legislation

A. Introduction

There are many situations that can lead to multiple types of legal complaints being launched. Where equality issues are at play, there is potential that both a human rights and a *Charter* complaint could be sustained. There is a recent trend towards using human rights legislation to address concerns that also lend themselves to *Charter* challenges. This is in part due to the nature of *Charter* litigation, which is complex, expensive and time-consuming. Human rights legislation offers a mechanism for assisting an individual in bringing a complaint through the Human Rights Commission, and is sometimes viewed as a more user-friendly process than a *Charter* claim or administrative law action through the judicial system.

In this part, we discuss how statutory human rights may be engaged, followed by a discussion of the basic test for discrimination and its application to the issue of EM in the forensic mental health patient population.

B. Relevance of Statutory Human Rights

A decision of the Review Board is likely to be immune from challenge before a statutory human rights tribunal by operation of the doctrine of adjudicative immunity. Adjudicative immunity means that the method of challenging the validity or correctness of an adjudicative decision should be through judicial review or the appeal mechanism set out in the board’s legislation, and not the *Human Rights Act*. Nonetheless, as a statutory decision-maker empowered to decide questions of law, the Review Board has the jurisdiction and duty to apply the "whole law" (including statutory human rights law) to matters properly arising before it. Arguably, this duty could be engaged where an individual at a Review Board disposition hearing wishes to argue that the Review Board's decision to require EM, or a decision or policy of hospital authorities to require EM, is inadequate to statutory human rights protections. A decision of the Review Board on this matter would be appealable to the Court of Appeal under

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246 See for example *Toronto v Canadian Union of Public Employees (CUPE), Local 79*, 2003 SCC 63, 3 SCR 77.

247 *Tranchemontagne v Ontario (Director, Disability Support Program)*, 2006 SCC 14, 1 SCR 513. See also *RWDSU v Dolphin Delivery Ltd*, [1986] 2 SCR 573, SCJ No 75 in which the Supreme Court of Canada stated that while courts were not actors to which the *Charter* applies, courts still had the responsibility to incorporate *Charter* analysis into their legal analysis. Arguably, the same may be said of an adjudicative / administrative decision-maker in relation to a quasi-constitutional human rights code.
section 672.72 of the *Criminal Code* which would then have jurisdiction to consider whether the decision or policy is consistent with human rights law.

The first issue to determine is whether the *Canadian Human Rights Act* or the Nova Scotia *Human Rights Act* applies. While the federal Act usually applies to matters falling under federal jurisdiction, such as criminal matters, the *Criminal Code* states that Review Boards are to be treated as being established under provincial laws.²⁴⁸ By virtue of this clause, it appears that an administrative inter-delegation has occurred. Inter-delegation is a constitutional principle whereby the federal government may delegate a federal power to an administrative body created by the provincial legislature.²⁴⁹ It would appear that such delegation carries with it a referential incorporation of provincial human rights laws. For this reason, we consider the application of an EM policy in the context of the Nova Scotia *Human Rights Act*. The relevant provisions of the Act are set out in Appendix F.

An alternative means of engaging statutory human rights law would be through a challenge to a decision or policy of hospital authorities through a complaint made to the Nova Scotia Human Rights Commission (rather than, as noted above, through arguments made before the Review Board at a disposition hearing). The doctrine of adjudicative immunity arguably does not apply to hospital authorities in this situation, on the thesis that they function as administrative rather than adjudicative bodies. However, as noted earlier, the discretionary decisions of hospital authorities on whether restrictions on liberty should be increased or decreased are "deemed" to be dispositions of the Review Board. Thus, it is arguable that these decisions should be similarly protected by the doctrine of adjudicative immunity thereby challengeable in light of statutory human rights principles only at the Review Board, or perhaps at the Court of Appeal.

### C. What Is Required to Establish a Claim of Discrimination?

There are two steps to establishing a claim of discrimination: (1) *prima facie* discrimination; and (2) justification.²⁵⁰

The first step is to demonstrate *prima facie* discrimination. To show a *prima facie* case, complainants must show that:

²⁴⁸ *Criminal Code*, RSC 1985, c C-46, s 672.38(2).


²⁵⁰ The test is set out in *Moore v British Columbia (Education)* 2012 SCC 61, 3 SCR 360 and recently affirmed by the Nova Scotia Human Rights Board of Inquiry in *Cromwell v Leon’s Furniture*, 2014 CanLII 16399 (NS HRC).
1. they have a characteristic protected from discrimination under the Act;
2. they experienced an adverse impact with respect to the service; and
3. the protected characteristic was a factor in the adverse impact.\textsuperscript{251}

Once a \textit{prima facie} case is established, “the burden shifts to the respondent to justify the conduct or practice, within the framework of the exemptions available under human rights statutes. If it cannot be justified, discrimination will be found to occur.”\textsuperscript{252} To justify the conduct, the respondent must prove:

(1) it adopted the standard for a purpose or goal rationally connected to the function being performed;
(2) it adopted the standard in good faith, in the belief that it is necessary for the fulfilment of the purpose or goal; and
(3) the standard is reasonably necessary to accomplish its purpose or goal and it is impossible to accommodate without incurring undue hardship.\textsuperscript{253}

1. \textbf{Is There \textit{Prima Facie} Discrimination?}

a) \textbf{Do Forensic Mental Health Patients Have a Characteristic Protected From Discrimination Under the Act?}

Patients detained under the Mental Disorder provisions by definition have a mental disorder which is a characteristic protected from discrimination under the \textit{Human Rights Act}.\textsuperscript{254} As such, they would satisfy this element of the \textit{prima facie} case.

b) \textbf{Do Forensic Mental Health Patients Experience an Adverse Impact With Respect to the Service?}

Two central questions arise when considering this aspect of the analysis: 1) Is there a “service” at issue within the meaning of the Act? and 2) Is there an adverse impact?

\textsuperscript{251} Moore v British Columbia (Education) 2012 SCC 61 at para 33, 3 SCR 360; Cromwell v Leon’s Furniture, 2014 CanLII 16399 at para 75 (NS HRC).
\textsuperscript{252} Moore v British Columbia (Education) 2012 SCC 61 at para 33, 3 SCR 360.
\textsuperscript{253} British Columbia (Public Service Employee Relations Commission) v BCGSEU, [1999] 3 SCR 3, SCJ No 46 (“Meiorin”); British Columbia (Superintendent of Motor Vehicles) v British Columbia (Council of Human Rights), [1999] 3 SCR 868, SCJ No 73 (“Grismer”).
\textsuperscript{254} Human Rights Act, RSNS 1989 c 214, s 5(1)(o).
1) Is There a “Service”?

Under section 5(1)(a) of the Nova Scotia *Human Rights Act*, no person shall discriminate on account of a mental disability “in respect of the provision of or access to services or facilities.” The word “service” is not defined in the Act. In determining whether something is a ‘service’ for the purposes of the Act, the Nova Scotia Court of Appeal has outlined the following considerations:

- employ a broad, liberal and purposive approach in interpreting the provisions of the Act, in a manner befitting the special nature of human rights legislation;
- the stated purpose of the Act, particularly s.2(e) which recognizes the responsibility which the government, all public agencies and persons in the province have to ensure equal opportunity to enjoy a full and productive life and that the failure to provide equal opportunity threatens the status of all persons;
- the lengths to which courts have gone to advance the broad policy considerations which underlie human rights legislation;
- the amendments to the Act which broaden the scope of the word “services” by the deletion of limiting phrases such as “customarily provided to members of the public”; and
- the nature and purpose of the legislative scheme at issue (in the case before the NSCA, it was workers’ compensation).\(^{255}\)

Central to the analysis of an EM policy are the Mental Disorder provisions under the *Criminal Code*. Their nature and purpose are not meant to impose a punishment, but rather they signal that the person “is to be treated with the utmost dignity and afforded the utmost liberty compatible with his or her situation. … [The Mental Disorder provisions emphasize] individualized assessment and the provision of opportunities for appropriate treatment.”\(^{256}\) Based on the broad and purposive approach applied by the courts and the legislative scheme under the *Criminal Code*, the “service” is likely to be defined in the Nova Scotia *Human Rights Act* as the structured access to the community as a component of forensic hospital services.

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2) **Is There an Adverse Impact?**

The analysis of the adverse impact relates to the definition of “discrimination” in section 4 of the Nova Scotia *Human Rights Act*. Under section 4, the key question is whether a distinction has “the effect of imposing burdens, obligations or disadvantages” on an individual or class of individuals not imposed on others.

It is possible that EM could serve to perpetuate negative stereotypes about the mentally ill and increase the stigma forensic mental health patients already face in reintegrating into society. In any case, EM places practical obligations on forensic mental health patients (e.g., physically wearing it, charging it, etc.). These would be factors in considering whether a distinction may be made out under the *Human Rights Act* that has the effect of imposing disadvantage. It would appear that a policy (whether blanket or individualized) requiring EM is likely to be recognized as placing a burden on forensic mental health patients based at least in part on their mental disability such that forensic mental health patients would experience an adverse impact with respect to forensic hospital services.

c) **Is the Protected Characteristic a Factor in the Adverse Impact?**

The protected characteristic does not have to be the sole factor in the adverse treatment, as long as it is a factor. As discussed above, forensic mental health patients by definition have a protected characteristic (mental disability) and an EM policy would be applied towards them, at least in part, because of that characteristic. This holds true whether it is a blanket or an individualized policy.

It may be argued that the adverse impact is not because of the mental disability but because of a risk to public safety. However, the risk that is purportedly being addressed arises because of their mental disability. Therefore, it is a factor in the adverse impact.

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257 See for example Queensland, Australia, Parliament, *Health and Community Services Committee: Queensland Mental Health Commission Bill 2012*, Submission 16 (5 February 2013) online: <http://www.parliament.qld.gov.au/documents/tableOffice/CommSubs/2013/QldMtlHlthComBill2012/016.pdf> at 2 (submitted on behalf of Dr. Rebekah Doley et al). For clarity, we note that stereotyping does not need to be established as part of the test for determining whether a policy has ‘the effect of imposing burdens, obligations or disadvantages’ on individuals not imposed on others.


259 As stated in *Mazzei*, “By the very definition of a verdict of ‘not criminally responsible on account of mental disorder,’ the accused’s mental condition is effectively the reason why the accused is now subject to Part XX.1, and in most cases it is the very reason why the accused represents a threat to public safety and why the accused’s liberty interests have been curtailed in accordance with that risk.” *Mazzei v British Columbia (Director of Adult Forensic Psychiatric Services)*, 2006 SCC 7 at para 41, 1 SCR 326.
It appears that there are factors that support a *prima facie* case and so it is possible that an EM policy could be exposed to a human rights claim. The next step, then, is to turn to the justification stage of the analysis.

2. **Is the Discrimination Justifiable?**

Once *prima facie* discrimination has been demonstrated, the burden shifts to the respondent to justify on a balance of probabilities the conduct or practice within the framework of the exemptions available under the legislation. Note that the Nova Scotia *Human Rights Act* includes a provision that states that the discrimination provisions do not apply “where a denial, refusal or other form of alleged discrimination is a reasonable limit prescribed by law as can be demonstrably justifiable in a free and democratic society.”260 This provision does not appear to have been subject to judicial commentary. However, we note that when conducting the justification analysis, the Human Rights Boards of Inquiry and Nova Scotia courts have adopted tests set out by the Supreme Court of Canada under human rights legislation. These cases require the respondent to prove:

1. it adopted the standard for a purpose or goal rationally connected to the function being performed;
2. it adopted the standard in good faith, in the belief that it is necessary for the fulfilment of the purpose or goal; and
3. the standard is reasonably necessary to accomplish its purpose or goal and it is impossible to accommodate without incurring undue hardship.261

a) **Is the Policy Adopted for a Purpose or Goal Rationally Connected to the Function Being Performed?**

The focus on the first step of this test is not the validity of the standard or policy, but the validity of its general purpose. In this case, the government’s stated goal of EM for forensic mental health patients is to improve public safety. The function being performed is the granting or restricting of patient’s access to the community on the conditions outlined in the Review Board disposition, as part of the delivery of forensic hospital services.

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Clearly, the goal of public safety is rationally connected to the function of determining the terms of a forensic patient’s access to the community. However, this goal will be subjected to a second level of scrutiny. It must be consistent with the legislative regime at issue.\textsuperscript{262}

The level of public safety sought through the use of EM must be consistent with the goal of patient reintegration and the value of patient liberty under the \textit{Criminal Code}. To require an absolute level of public safety would not be feasible as the only way to achieve that would be to deny all community access contrary to the twin goals under the \textit{Criminal Code}. As the Supreme Court of Canada stated in \textit{Pinet}:

\begin{quotation}
… even where a risk to the public safety is established, the conditions of the disposition order are to be ‘the least onerous and least restrictive to the accused’ consistent with the level of risk posed considering the mental condition of the NCR accused, the objective of eventual reintegration into the community and his or her other needs.\textsuperscript{263}
\end{quotation}

We believe the goal of public safety consistent with the other requirements of the \textit{Criminal Code} would be found to be rationally connected to community access as part of the delivery of forensic hospital services.

\textbf{b) Is the Policy Adopted in Good Faith, in the Belief That It Is Necessary for the Fulfilment of the Purpose or Goal?}

At this stage of the test, the government must establish that it adopted the policy in an honest and good faith belief that it was necessary to fulfill a legitimate purpose or goal.

The fact that the government is engaging in research and, as we understand it, discussions with stakeholders about an EM policy may be seen to indicate good faith. However, the Supreme Court of Canada has stated that “if the imposition of the standard was not thought to be reasonably necessary or was motivated by discriminatory animus, then it cannot be a [\textit{bona fide} requirement]\textsuperscript{264} and would therefore fail this stage of the test. If the policy is found to be motivated by discriminatory public attitudes rather than grounded in evidence or reasonable inferences from the evidence, then it would fail this stage of the test. However, it appears that

\textsuperscript{262} \textit{British Columbia (Superintendent of Motor Vehicles) v British Columbia (Council of Human Rights),} [1999] 3 SCR 868, SCJ No 73 (“Grismer”).

\textsuperscript{263} \textit{Pinet v St. Thomas Psychiatric Hospital}, 2004 SCC 21, at para 21, 1 SCR 528.

\textsuperscript{264} \textit{British Columbia (Public Service Employee Relations Commission) v BCGSEU,} [1999] 3 SCR 3 at para 60, SCJ No 46 (“Meiorin”).
the threshold for satisfying the good faith stage of the test may be lower than what is required for satisfying the remaining elements of the justification analysis. 265

c) Is the Standard Reasonably Necessary to Accomplish the Purpose or Goal? Can the Claimant(s) Be Accommodated Without Undue Hardship?

At this stage of the justification, the analysis shifts from the general purpose of the policy to the particular policy. The Supreme Court of Canada has stated, “Having chosen and defined the purpose or goal – be it safety, efficiency, or any other valid object – the focus shifts to the means by which the employer or service provider seeks to achieve the purpose or goal.”266 (emphasis in original.) The final stage of the justification analysis is to show that the standard is reasonably necessary to accomplish the legitimate purpose. To meet this requirement, the respondent must demonstrate “that the standard incorporates every possible accommodation to the point of undue hardship, whether that hardship takes the form of impossibility, serious risk or excessive cost.”267

Under this element of the test, the government will need to show that the mandatory use of GPS bracelets for forensic mental health patients in the community furthers the goal of public safety consistent with the other requirements of the Criminal Code and that there are no less restrictive alternatives that could be utilized to accommodate its purpose short of undue hardship.

At this final stage of the analysis, consideration must be given to:

1) the process, if any, which was adopted to assess the issue of accommodation; and
2) the substantive content of either a more accommodating standard or the reasons for not offering alternatives.

1) Process

To satisfy the procedural element of the test, the government must show that it considered and reasonably rejected all other viable forms of accommodation. The government will need to turn its mind to whether there are less restrictive ways of achieving the goal of public safety consistent with the other requirements of the Criminal Code. The Supreme Court of Canada

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265 British Columbia (Superintendent of Motor Vehicles) v British Columbia (Council of Human Rights), [1999] 3 SCR 868 at para 28, SCJ No 73 (“Grismer”).
266 British Columbia (Superintendent of Motor Vehicles) v British Columbia (Council of Human Rights), [1999] 3 SCR 868 at para 21, SCJ No 73 (“Grismer”).
offered guidance on some of the important questions that should be asked about accommodation when developing a policy. They are:

- Were alternative approaches that do not have a discriminatory effect investigated, such as individual testing against a more individually sensitive standard?
- If alternative standards/tools were investigated and found to be capable of fulfilling the purpose, why were they not implemented?
- Is a single standard/tool necessary or could standards/tools reflective of individual differences and capabilities be established?
- Is there a way to monitor community access that is less discriminatory while still accomplishing the goal?
- Is the standard/tool properly designed to ensure that the desired goal is met without placing an undue burden on those to whom the standard/tool is applied?
- Have other parties who are obliged to assist in the search for possible accommodation fulfilled their roles?  

We understand that the government is engaging in efforts to address many of these questions raised by the Court. In addition to the research and analysis in this report, we understand that research is being conducted with respect to the effectiveness of EM and the experience of EM with the forensic mental health population in other jurisdictions to inform the government’s decision. We also understand that the government is engaging with staff at the ECFH who deliver the forensic hospital services. The government needs to consider whether there are alternatives to EM that would fulfill the purpose. The government needs to consider whether the procedural changes adopted in 2012-2013 are sufficient to meet the goal of public safety consistent with the other requirements of the *Criminal Code*, such that further measures are unwarranted.

2) **Substantive Content**

There are two questions that must be addressed under this portion of the test. Is EM reasonably necessary to protect public safety consistent with the other requirements of the *Criminal Code*? And, if yes, are there alternatives or different ways of implementing that could fulfill the purpose of public safety consistent with the other requirements of the *Criminal Code*?

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268 *British Columbia (Public Service Employee Relations Commission) v BCGSEU*, [1999] 3 SCR 3 at para 65, SCJ No 46 (“Meiorin”).
(i) Is EM Reasonably Necessary to Protect Public Safety?

In order to satisfy this element of the test, it would be necessary to show that there is a risk to public safety that is not adequately addressed by current measures but could be addressed by EM. In this regard the information discussed in relation to the “necessary and appropriate,” as well as least onerous and least restrictive, conditions consistent with public safety in Parts IV and V of this report is relevant. We refer back to that discussion and do not repeat the information here.

Based on that discussion, it could be argued that the measures currently in place, including the new measures in place since 2012-2013, to address public safety when deciding whether and how to grant community access are effective such that the goal of public safety consistent with the other requirements of the Criminal Code is already met. Although the risk to the public may be low, the consequence of the risk materializing was horrific in the 2012 incident. This would affect the analysis of whether the additional tool of EM is “reasonably necessary” to address that risk. As noted earlier, the Supreme Court of Canada has indicated that the magnitude of the harm needs to be balanced as against its probability.269

Risk can be considered as part of the analysis of undue hardship. In Grismer, the Supreme Court of Canada adverted to risk as a measure of the level of highway safety which was sought by the Superintendent of Motor Vehicles, and as a factor in assessing the lack of accommodation provided by the Superintendent for people with a certain visual condition. In that case, the legitimate goal of the Superintendent was not “absolute” highway safety, but rather “reasonable” highway safety. In the context of EM, the critical issue is whether the use of EM is reasonably necessary to achieve the legitimate purpose contemplated in the level of public safety consistent with the other requirements of the Criminal Code.

This leads to the question of whether EM is a tool that can help prevent violent incidents. As indicated in the discussion under Parts IV and V of this report, there is little information related to the effectiveness that EM may have on responding to a risk of violence when forensic mental health patients exercise community access. We are unaware of information or data indicating a correlation between incidents of violence and patients being off of their itinerary or staying out too long.

If a policy to require EM were to be implemented, it would be important to identify evidence that tracking the individual’s movements can assist in reducing an already small number of violent incidents. As was seen earlier in the discussion under Part IV, the pilot project in England

269 Winko v British Columbia (Forensic Psychiatric Institute), [1999] 2 SCR 625 at paras 56-58, SCJ No 31.
concluded that under their model, GPS tracking deterred patients from absconding; however, the project did not provide information about violent incidents nor specifically whether GPS tracking had an effect on preventing or minimizing violent incidents. We also note the concern expressed by the Queensland Branch Committee of the Faculty of Forensic Psychiatry that the mandatory GPS tracking could have the ironic effect of exacerbating the potential risks of adverse incidents due to the erosion of therapeutic trust.\textsuperscript{270}

It also would be important for the government to consider whether a policy regarding the use of EM may be counter-productive with regard to the goal of public safety consistent with the other requirements of the \textit{Criminal Code}. There has been suggestion that the harm EM may do to the therapeutic relationship, and the ability of a patient to develop the skills to self-monitor, may end up placing the public at greater risk.\textsuperscript{271} The study of EM in the Netherlands found that the use of EM may create a false sense of security in that one knows where the person is, but not what the person is doing. Also, concern was raised in the Netherlands study that there could be a reduction in the amount of personal contact between the wearer and the institution during the period of leave.

It is possible that implementation of GPS monitoring would increase levels of public confidence. We understand that information gathered by the Nova Scotia Health Research Foundation through interviews with individuals involved with GPS monitoring programs in England and Australia indicates that GPS monitoring of forensic patients may provide assurances to the broader community and make people who live near mental health facilities feel safer in the knowledge that the hospital is taking necessary precautions when patients are accessing the community. In considering community attitudes towards GPS monitoring of forensic mental health patients, it will be necessary for the government to consider evidence about the effectiveness of the monitoring in relation to an actual increase in public safety, as courts have found that attitudes based on stereotypical or otherwise discriminatory assumptions and


impressionistic evidence cannot be determinative of whether a policy accommodates to the point of undue hardship. Courts have explicitly rejected the argument that a discriminatory standard ought to be upheld because abandoning the standard would negatively affect workplace morale. This may be analogous to community morale about forensic mental health patients being granted community access.

In order to satisfy this element of the test, government would need to show that there is a risk to public safety that is not adequately addressed by current measures and that it is reasonable to assume that EM would enhance public safety consistent with the other requirements of the Criminal Code. Based on the evidence we have reviewed and which is set out in Part IV of this report, it is not clear that this can be established.

(ii) Are There Alternatives or Different Ways of Implementing That Could Fulfil the Purpose?

In assessing whether the policy is reasonably necessary, the government will need to show that alternative approaches to enhancing public safety were considered but found inadequate to accomplish the goal. In other words, the government must show “that it could not have done anything else reasonable or practical to avoid the negative impact on the individual.”

We consider the arguments likely to arise under each of the options suggested by government: a blanket policy requiring EM of all forensic hospital patients accessing the community; a policy requiring EM based in individualized assessment; and the status quo (no EM required of any patients accessing the community).

**EM as a necessary condition of community access (“blanket” policy)**

If the government chooses to implement a policy where all forensic mental health patients must wear a GPS bracelet during community access, without an individualized assessment as to risk, it would need to show that this approach is reasonably necessary in order to ensure a level of public safety consistent with the patient’s interest in liberty, his/her therapeutic interests, and the broader public interest in community reintegration. It must also be shown that the risk to public

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272 Saskatchewan (Human Rights Commission) v Moose Jaw (City), [1989] 2 SCR 1317, SCJ No 128; British Columbia (Public Service Employee Relations Commission) v BCGSEU, [1999] 3 SCR 3 at para 80, SCJ No 46 (“Meiorin”).

273 British Columbia (Public Service Employee Relations Commission) v BCGSEU, [1999] 3 SCR 3 at para 80, SCJ No 46 (“Meiorin”).

274 British Columbia (Public Service Employee Relations Commission) v BCGSEU, [1999] 3 SCR 3 at para 38, SCJ No 46 (“Meiorin”).
safety is mitigated by the GPS bracelet. The information discussed in Part IV of this report related to the low frequency of violent incidents committed by forensic mental health patients and the lack of information correlating incidents of violence with patients being off of their itineraries or staying out too long suggests this may be challenging to demonstrate. We also suggest that this claim would be difficult to establish because EM cannot guarantee that there would be no violent incidents while patients are in the community; EM can only indicate where individuals are, not what they are doing.

Where a blanket policy is in place, the government would need to demonstrate the link between the goal of public safety consistent with the other requirements of the Criminal Code, and the outright refusal of even the possibility for an individual forensic mental health patient to demonstrate that he/she does not present an undue threat to safety if granted community access without the use of a GPS bracelet.\textsuperscript{275}

**EM as a requirement based in individualized risk assessment v. the status quo**

The conduct of an individual assessment to determine whether a GPS bracelet must be worn would aid in establishing reasonable accommodation. However, the policy still must meet the least restrictive means of achieving the goal. In a case known as Meiorin, the Supreme Court of Canada found that although firefighting candidates were individually assessed, the standard for aerobic capacity was not reasonably necessary to do the job of firefighting safely.\textsuperscript{276}

In considering the individual risk assessment as part of determining whether a patient is required to wear a GPS bracelet in the community, the government must weigh the effectiveness of GPS monitoring in advancing the goal of public safety consistent with the other requirements of the Criminal Code, and consider whether there are less restrictive but effective ways of achieving that goal.

It will be important to consider whether the new procedures adopted following the 2012 incident that resulted in murder charges adequately address risks about public safety consistent with the other requirements of the Criminal Code. It will also be important to consider whether maintaining or enhancing the current procedures constitute less restrictive ways of achieving the goal of public safety consistent with the other requirements of the Criminal Code. For instance, would increasing the use of community monitors or cell phone check-ins be effective alternatives to the use of a GPS bracelet that would be less burdening from a human rights perspective?

\textsuperscript{275} British Columbia (Superintendent of Motor Vehicles) v British Columbia (Council of Human Rights), [1999] 3 SCR 868 at para 44, SCJ No 73 (“Grismer”).

\textsuperscript{276} British Columbia (Public Service Employee Relations Commission) v BCGSEU, [1999] 3 SCR 3, SCJ No 46 (“Meiorin”).
As indicated in Part IV of this report, it is difficult to say whether these and other recently implemented measures have impacted public safety. This is due to the low frequency of violent incidents overall. Staff at the ECFH indicated that they believe the new processes have reduced AWOL incidents and have enhanced rehabilitation processes. There have not been any known violent incidents since the revised procedures were implemented.

In light of the earlier discussion about whether EM helps to reduce violent incidents, the government needs to consider whether the goal of public safety is already met through these new procedures. If this is the case, the status quo may be adequate such that it is the appropriate ‘alternative’ to EM to avoid the potentially negative impact to the individual.

Based on the information discussed here and in Part IV of the report, it appears that EM may not be the least restrictive means, and possibly not even an effective means, of achieving the goal of public safety consistent with the patient’s interest in liberty, his or her therapeutic interests and the broader public interest in community reintegration. It would appear that a policy requiring the use of EM when patients exercise community access could face a forceful challenge under human rights legislation. The government should be aware of the need to support any policy which it develops to use EM in information and evidence, and be able to present such information if challenged. Based on the information of which we are aware, it may be difficult to successfully respond to a human rights complaint.

D. Conclusion on Human Rights Legislation

There appears to be a significant likelihood that a claimant would be successful where a challenge to a law, policy or decision imposing EM as a condition of community access is based in the principles of statutory human rights law. We reach this conclusion because, based on the information of which we are aware, it is not clear that EM is reasonably necessary to protect public safety consistent with the other requirements of the Criminal Code. Further, it would appear that there are alternate methods of achieving the goal of public safety consistent with the other requirements of the Criminal Code, that are less restrictive than the use of EM. While “discrimination” is likely to be established whether through section 15 of the Charter or the prima facie stage of a human rights claim, statutory human rights principles do not include the imperative of deference to government as is often engaged under section 1 of the Charter. As a result, such a claim (which may be engaged through the requirement that the Review Board apply human rights legislation in matters properly before it, or, potentially, through a human rights proceeding targeting a hospital decision) has a greater likelihood of success than a Charter claim.

Appendix B, Dr. Aileen Brunet, Clinical Director, East Coast Forensic Hospital (19 June 2014) “East Coast Forensic Hospital Process Changes Subsequent to 2012.”
This conclusion is subject to the caveat that the Human Rights legislation has a unique provision that has language which is very similar to section 1 of the *Charter*. This provision has never been judicially considered. If it is interpreted to be consistent with section 1 *Charter* jurisprudence, then a decision-maker may show deference to the government and the likelihood of success will be similar to that described above for a section 15 challenge.
Appendix A

Select Criminal Code Sections
Appendix A – Select *Criminal Code* Sections

“hospital”

“hospital” means a place in a province that is designated by the Minister of Health for the province for the custody, treatment or assessment of an accused in respect of whom an assessment order, a disposition or a placement decision is made;

**Review Boards**

*Review Boards to be Established*

672.38 (1) A Review Board shall be established or designated for each province to make or review dispositions concerning any accused in respect of whom a verdict of not criminally responsible by reason of mental disorder or unfit to stand trial is rendered, and shall consist of not fewer than five members appointed by the lieutenant governor in council of the province.

*Treated as Provincial Board*

(2) A Review Board shall be treated as having been established under the laws of the province.

*Personal Liability*

(3) No member of a Review Board is personally liable for any act done in good faith in the exercise of the member’s powers or the performance of the member’s duties and functions or for any default or neglect in good faith in the exercise of those powers or the performance of those duties and functions.

*Rules of Review Board*

672.44 (1) A Review Board may, subject to the approval of the lieutenant governor in council of the province, make rules providing for the practice and procedure before the Review Board.

*Application and Publication of Rules*

(2) The rules made by a Review Board under subsection (1) apply to any proceeding within its jurisdiction, and shall be published in the *Canada Gazette*. 
(3) Notwithstanding anything in this section, the Governor in Council may make regulations to provide for the practice and procedure before Review Boards, in particular to make the rules of Review Boards uniform, and all regulations made under this subsection prevail over any rules made under subsection (1).

**Dispositions by a Court or Review Board**

**Dispositions that May be Made**

672.54 When a court or Review Board makes a disposition under subsection 672.45(2), section 672.47, subsection 672.64(3) or section 672.83 or 672.84, it shall, taking into account the safety of the public, which is the paramount consideration, the mental condition of the accused, the reintegration of the accused into society and the other needs of the accused, make one of the following dispositions that is necessary and appropriate in the circumstances:

(a) where a verdict of not criminally responsible on account of mental disorder has been rendered in respect of the accused and, in the opinion of the court or Review Board, the accused is not a significant threat to the safety of the public, by order, direct that the accused be discharged absolutely;

(b) by order, direct that the accused be discharged subject to such conditions as the court or Review Board considers appropriate; or

(c) by order, direct that the accused be detained in custody in a hospital, subject to such conditions as the court or Review Board considers appropriate.

**Significant threat to safety of public**

672.5401 For the purposes of section 672.54, a significant threat to the safety of the public means a risk of serious physical or psychological harm to members of the public — including any victim of or witness to the offence, or any person under the age of 18 years — resulting from conduct that is criminal in nature but not necessarily violent.

**Victim impact statement**

672.541 If a verdict of not criminally responsible on account of mental disorder has been rendered in respect of an accused, the court or Review Board shall

(a) at a hearing held under section 672.45, 672.47, 672.64, 672.81 or 672.82 or subsection 672.84(5), take into consideration any statement filed by a victim in accordance with subsection 672.5(14) in determining the appropriate disposition or conditions under section 672.54, to the extent that the statement is relevant to its consideration of the criteria set out in section 672.54;

(b) at a hearing held under section 672.64 or subsection 672.84(3), take into consideration any statement filed by a victim in accordance with subsection
672.5(14), to the extent that the statement is relevant to its consideration of the criteria set out in subsection 672.64(1) or 672.84(3), as the case may be, in deciding whether to find that the accused is a high-risk accused, or to revoke such a finding; and

(c) at a hearing held under section 672.81 or 672.82 in respect of a high-risk accused, take into consideration any statement filed by a victim in accordance with subsection 672.5(14) in determining whether to refer to the court for review the finding that the accused is a high-risk accused, to the extent that the statement is relevant to its consideration of the criteria set out in subsection 672.84(1).

Additional conditions — safety and security

672.542 When a court or Review Board holds a hearing referred to in section 672.5, the court or Review Board shall consider whether it is desirable, in the interests of the safety and security of any person, particularly a victim of or witness to the offence or a justice system participant, to include as a condition of the disposition that the accused

(a) abstain from communicating, directly or indirectly, with any victim, witness or other person identified in the disposition, or refrain from going to any place specified in the disposition; or

(b) comply with any other condition specified in the disposition that the court or Review Board considers necessary to ensure the safety and security of those persons.

Treatment Not a Condition

672.55(1) No disposition made under section 672.54 shall direct that any psychiatric or other treatment of the accused be carried out or that the accused submit to such treatment except that the disposition may include a condition regarding psychiatric or other treatment where the accused has consented to the condition and the court or Review Board considers the condition to be reasonable and necessary in the interests of the accused.

(2) [Repealed, 2005, c. 22, s. 22]

Delegated Authority to Vary Restrictions on Liberty of Accused

672.56(1) A Review Board that makes a disposition in respect of an accused under paragraph 672.54(b) or (c) may delegate to the person in charge of the hospital authority to direct that the restrictions on the liberty of the accused be increased or decreased within any limits and subject to any conditions set out in that disposition, and any direction so made is deemed for the purposes of this Act to be a disposition made by the Review Board.
**Exception — high-risk accused**

(1.1) If the accused is a high-risk accused, any direction is subject to the restrictions set out in subsection 672.64(3).

**Notice to Accused and Review Board of Increase in Restrictions**

(2) A person who increases the restrictions on the liberty of the accused significantly pursuant to authority delegated to the person by a Review Board shall

(a) make a record of the increased restrictions on the file of the accused; and

(b) give notice of the increase as soon as is practicable to the accused and, if the increased restrictions remain in force for a period exceeding seven days, to the Review Board.

**High-Risk Accused**

**Finding**

672.64 (1) On application made by the prosecutor before any disposition to discharge an accused absolutely, the court may, at the conclusion of a hearing, find the accused to be a high-risk accused if the accused has been found not criminally responsible on account of mental disorder for a serious personal injury offence, as defined in subsection 672.81(1.3), the accused was 18 years of age or more at the time of the commission of the offence and

(a) the court is satisfied that there is a substantial likelihood that the accused will use violence that could endanger the life or safety of another person; or

(b) the court is of the opinion that the acts that constitute the offence were of such a brutal nature as to indicate a risk of grave physical or psychological harm to another person.

**Factors to consider**

(2) In deciding whether to find that the accused is a high-risk accused, the court shall consider all relevant evidence, including

(a) the nature and circumstances of the offence;

(b) any pattern of repetitive behaviour of which the offence forms a part;

(c) the accused’s current mental condition;

(d) the past and expected course of the accused’s treatment, including the accused’s willingness to follow treatment; and

(e) the opinions of experts who have examined the accused.


**Detention of high-risk accused**

(3) If the court finds the accused to be a high-risk accused, the court shall make a disposition under paragraph 672.54(c), but the accused’s detention must not be subject to any condition that would permit the accused to be absent from the hospital unless

(a) it is appropriate, in the opinion of the person in charge of the hospital, for the accused to be absent from the hospital for medical reasons or for any purpose that is necessary for the accused’s treatment, if the accused is escorted by a person who is authorized by the person in charge of the hospital; and

(b) a structured plan has been prepared to address any risk related to the accused’s absence and, as a result, that absence will not present an undue risk to the public.

**Appeal**

(4) A decision not to find an accused to be a high-risk accused is deemed to be a disposition for the purpose of sections 672.72 to 672.78.

**For greater certainty**

(5) For greater certainty, a finding that an accused is a high-risk accused is a disposition and sections 672.72 to 672.78 apply to it.

**Appeals**

**Grounds for Appeal**

672.72 (1) Any party may appeal against a disposition made by a court or a Review Board, or a placement decision made by a Review Board, to the court of appeal of the province where the disposition or placement decision was made on any ground of appeal that raises a question of law or fact alone or of mixed law and fact.

**Limitation Period for Appeal**

(2) An appellant shall give notice of an appeal against a disposition or placement decision in the manner directed by the applicable rules of court within fifteen days after the day on which the appellant receives a copy of the placement decision or disposition and the reasons for it or within any further time that the court of appeal, or a judge of that court, may direct.
**Appeal to be Heard Expeditiously**

(3) The court of appeal shall hear an appeal against a disposition or placement decision in or out of the regular sessions of the court, as soon as practicable after the day on which the notice of appeal is given, within any period that may be fixed by the court of appeal, a judge of the court of appeal, or the rules of that court.

**Powers of court of appeal**

672.78 (1) The court of appeal may allow an appeal against a disposition or placement decision and set aside an order made by the court or Review Board, where the court of appeal is of the opinion that

(a) it is unreasonable or cannot be supported by the evidence;

(b) it is based on a wrong decision on a question of law; or

(c) there was a miscarriage of justice.

**Idem**

(2) The court of appeal may dismiss an appeal against a disposition or placement decision where the court is of the opinion

(a) that paragraphs (1)(a), (b) and (c) do not apply; or

(b) that paragraph (1)(b) may apply, but the court finds that no substantial wrong or miscarriage of justice has occurred.

**Orders that the court may make**

(3) Where the court of appeal allows an appeal against a disposition or placement decision, it may

(a) make any disposition under section 672.54 or any placement decision that the Review Board could have made;

(b) refer the matter back to the court or Review Board for re-hearing, in whole or in part, in accordance with any directions that the court of appeal considers appropriate; or

(c) make any other order that justice requires.
Review of Dispositions

Mandatory Review of Dispositions

672.81 (1) A Review Board shall hold a hearing not later than twelve months after making a disposition and every twelve months thereafter for as long as the disposition remains in force, to review any disposition that it has made in respect of an accused, other than an absolute discharge under paragraph 672.54(a).

Extension on Consent

(1.1) Despite subsection (1), the Review Board may extend the time for holding a hearing to a maximum of twenty-four months after the making or reviewing of a disposition if the accused is represented by counsel and the accused and the Attorney General consent to the extension.

Extension for Serious Personal Violence Offence

(1.2) Despite subsection (1), at the conclusion of a hearing under this section the Review Board may, after making a disposition, extend the time for holding a subsequent hearing under this section to a maximum of twenty-four months if

(a) the accused has been found not criminally responsible for a serious personal injury offence;

(b) the accused is subject to a disposition made under paragraph 672.54(c); and

(c) the Review Board is satisfied on the basis of any relevant information, including disposition information within the meaning of subsection 672.51(1) and an assessment report made under an assessment ordered under paragraph 672.121(a), that the condition of the accused is not likely to improve and that detention remains necessary for the period of the extension.

Definition of “Serious Personal Injury Offence”

(1.3) For the purposes of subsection (1.2), “serious personal injury offence” means

(a) an indictable offence involving
   (i) the use or attempted use of violence against another person, or
   (ii) conduct endangering or likely to endanger the life or safety of another person or inflicting or likely to inflict severe psychological damage upon another person; or
(b) an indictable offence referred to in section 151, 152, 153, 153.1, 155, 160, 170, 171, 172, 271, 272 or 273 or an attempt to commit such an offence.

Extension on consent — high-risk accused

(1.31) Despite subsections (1) to (1.2), the Review Board may extend the time for holding a hearing in respect of a high-risk accused to a maximum of 36 months after making or reviewing a disposition if the accused is represented by counsel and the accused and the Attorney General consent to the extension.

Extension — no likely improvement

(1.32) Despite subsections (1) to (1.2), at the conclusion of a hearing under subsection 672.47(4) or this section in respect of a high-risk accused, the Review Board may, after making a disposition, extend the time for holding a subsequent hearing under this section to a maximum of 36 months if the Review Board is satisfied on the basis of any relevant information, including disposition information as defined in subsection 672.51(1) and an assessment report made under an assessment ordered under paragraph 672.121(c), that the accused’s condition is not likely to improve and that detention remains necessary for the period of the extension.

Notice

(1.4) If the Review Board extends the time for holding a hearing under subsection (1.2) or (1.32), it shall provide notice of the extension to the accused, the prosecutor and the person in charge of the hospital where the accused is detained.

Appeal

(1.5) A decision by the Review Board to extend the time for holding a hearing under subsection (1.2) is deemed to be a disposition for the purpose of sections 672.72 to 672.78.

Additional Mandatory Reviews in Custody Cases

(2) The Review Board shall hold a hearing to review any disposition made under paragraph 672.54(b) or (c) as soon as practicable after receiving notice that the person in charge of the place where the accused is detained or directed to attend requests the review.
**Review in Case of Increase on Restrictions on Liberty**

(2.1) The Review Board shall hold a hearing to review a decision to significantly increase the restrictions on the liberty of the accused, as soon as practicable after receiving the notice referred to in subsection 672.56(2).

**Idem**

(3) Where an accused is detained in custody pursuant to a disposition made under paragraph 672.54(c) and a sentence of imprisonment is subsequently imposed on the accused in respect of another offence, the Review Board shall hold a hearing to review the disposition as soon as is practicable after receiving notice of that sentence.

**Discretionary Review**

672.82 (1) A Review Board may hold a hearing to review any of its dispositions at any time, of its own motion or at the request of the accused or any other party.

**Review Board to Provide Notice**

(1.1) Where a Review Board holds a hearing under subsection (1) of its own motion, it shall provide notice to the prosecutor, the accused and any other party.
Appendix B

“East Coast Forensic Hospital Process Changes Subsequent to 2012”

Authored by Dr. Aileen Brunet
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June 19, 2014
Appendix B – East Coast Forensic Hospital Process Changes Subsequent to 2012

Authored by Dr. Aileen Brunet, Clinical Director, East Coast Forensic Hospital
June 19, 2014

This document summarizes many of the changes developed and implemented by the East Coast Forensic Hospital (ECFH) subsequent to an external joint review of the ECFH’s community access policies. The review was done in response to a serious incident that occurred in April 2012 during which an ECFH patient, while absent without leave from a one hour community access pass, was charged with the murder of a stranger in the community. The changes summarized in this document are ones which focus most directly on issues broadly related to public safety. Of note, the review recommendations did not arise from an examination of the incident itself or of any other occurrences and therefore are theoretically and speculatively related to broad issues of public safety rather then being evidence based. Please note that not all possible rationales for each change are listed; for example the Joint Review noted that a number of changes would lead to “greater consistency, transparency and accountability” whereas this document only refers to those rationales and consequences of the changes that can be relatively directly linked to potential public safety issues.

**Change:** Within hospital smoking area provided for patients.
**Origin** of Change: Department of Health and Wellness
**Rationale:** To end the one hour off site passes that patients had used to smoke and therefore reduce opportunities for patients to go AWOL.
**When Implemented:** April 2013

**Change:** Elimination of indirectly supervised community access prior to the patient’s initial Criminal Code Review Board (CCRB) hearing.
**Origin:** Joint Review recommendation
**Rationale:** Patients were independently accessing the community without having had a formal risk assessment completed and hearing of the case by the CCRB. Ending these passes reduced opportunities for AWOLs and ensured that all patients had had a formal risk assessment completed prior to decisions being made about community access. There had not been any AWOL incidents committed by patients using these passes.
**When Implemented:** Immediately after the Joint Review report was received in September 2012.

**Change:** Elimination of one hour indirectly supervised community access passes
**Origin:** ECFH
**Rationale:** One hour passes resulted in an excessive amount of daily traffic of patients in and out of the facility, potentially compromising security and taking away from clinical time of
frontline staff. ECFH staff tended to regard one hour passes as lower risk (for AWOLs and problematic behaviour) than longer passes. Increasing the minimum indirectly supervised pass to three hours requires clinical teams to closely consider the readiness of patients for indirectly supervised passes.

**When Implemented:** July 2013

**Change:** Providing patients with cell phones for use during indirectly supervised passes

**Origin:** Joint Review

**Rationale:** Allows for staff and patients to have contact during a pass; can allow for a mental status check, provide direction to patients regarding the need to return to hospital immediately and allows patients to contact staff if they’ve encountered difficulty or have changed their itinerary.

**When Implemented:** July 2013

**Change:** Development of a community monitor position.

**Origin:** ECFH

**Rationale:** The community monitor checks on patients’ whereabouts when they are in the community on indirectly supervised passes and using an itinerary (a predetermined schedule for their pass). This allows for the detection of patients not following their itineraries and earlier detection of patients who may be going AWOL by deliberately not returning to the hospital.

**When Implemented:** October 2012

**Change:** Development of a formal pre-pass mental state assessment of patients.

**Origin:** Joint Review

**Rationale:** To ensure that patients accessing the community independently have their mental state considered by frontline staff before being signed out on their pass.

**When Implemented:** July 2013

**Change:** Development of the Critical Behaviour Tracking Form (CBTF) and the Aggressive Incidents Scale (AIS). The AIS records aggressive incidents that may have occurred and the response provided to them by staff. The CBTF collects dynamic risk relevant information for a month on a single page; this includes the AIS, time spent by the patient in seclusion and the patients’ Imminent Risk Rating Scale (IRRS) scores.

**Origin:** Joint Review/ECFH

**Rationale:** The AIS and CBTF allow for the structured, formal collection of information that is relevant to and required for decisions clinical teams and administration make about patients’ community access. Prior to the implementation of these tools the risk related factors were not explicitly considered in a structured manner.

**When Implemented:** July 2013
Change: Development of the Structured Clinical Guide to AWOL Risk (SCAR). The SCAR is a 15 item measure derived from a literature review that assists with assessing a patient’s risk of going AWOL.
Origin: Joint Review
Rationale: Provides for the deliberate and empirically informed consideration by clinical teams of an individual patient’s risk of going AWOL and thus will impact community access decisions.
When Implemented: July 2013

Change: Development of the Patient Risk Summary (PRS), a document that captures the current SCAR, IRRS and AIS scores as well as information from the CBTF and additional risk related information such as the patient’s floor level of long term risk of violence and the current management of dynamic risk factors.
Origin: Joint Review/ECFH
Rationale: The PRS is updated and reviewed at every team meeting at which community access changes are being considered. This allows for explicit examination by the team of factors relevant to a patient’s shorter term risk of violence as well as of going AWOL. Additionally, the PRS is attached to Community Access Forms and is therefore reviewed by the Community Access Oversight Committee, the Program Leader and Administrator in Charge of the Hospital.
When Implemented: July 2013

Change: Revision of the form completed by clinical teams to request changes to the community access of patients.
Origin: Joint Review/ECFH
Rationale: The new form explicitly directs teams to consider the PRS data, potential victim impact of passes and risk related information, such as mental status, substance use, recent AWOLs etc. Processes related to completion of the form also require a team meeting to discuss community access for a patient and a minimum number of clinical team members to sign it. This improves the decision making process of the team and also provides important information to the Community Access Oversight Committee, the Program Leader and Administrator in Charge of the Hospital.
When Implemented: July 2013

Change: The Community Access Oversight Committee (CAOC) was established. This consists of senior clinical and administrative staff of the ECFH, of whom three must review Community Access forms completed by clinical teams and then sign them as approved or not before they are passed on to the Program Leader and then the Administrator in Charge of the Hospital.
Origin: Joint Review
Rationale: To provide for an additional, objective layer of accountability and review that is external to the clinical team in decisions about patients’ community access.
When Implemented: July 2013

Change: The definition of what constitutes an incident of a patient being absent without leave (AWOL) was made more explicit and the process for formally declaring a patient AWOL was
tightened. Extensions of passes for patients who called in to report that they were going to be late or who were suspected of being ‘innocently’ late returning to the hospital were discontinued. The definition of an AWOL was clarified to include patients not being at the locations they’d laid out on their itinerary prior to going on passes. It was also clarified that the process staff have to follow to ensure that a patient is AWOL and then contact police is to take no more than 10 minutes past the time the patient was meant to have returned.

**Origin:** Joint Review/ECFH

**Rationale:** These changes provided for a consistent approach for determining whether and AWOL had occurred and allowed for quicker notification of police and relevant staff and administrators in the event of an AWOL.

**When Implemented:** July 2013

**Change:** Automatic suspension of community access for a minimum of 72 hours whenever a patient has been AWOL and development of a process to review the AWOL incident. Clinical team members meet following a patient AWOL to reviewed the circumstances of it and complete a Post-AWOL Review form which is then forwarded to the Program Leader before community access can be reinstated.

**Origin:** Joint Review

**Rationale:** To improve the understanding of why patients have gone AWOL, convey the seriousness of such incidents to staff and patients and allow for teams to address contributing factors, which are then taken into account for decisions about community access. This process also insures there is consistency across teams in responding to AWOLs. Improving patients’ accountability for managing themselves in the community addresses their risk of AWOL as well as violence. The new AWOL policy does allow, with the approval of the Clinical Director and the Program Leader, for consideration of an exemption from the 72 hour suspension of community access if the patient’s rehabilitation or community reintegration would be seriously negatively affected. This may occur, for example, if the patient has employment, educational or other significant commitments in the community that could be lost if they cannot attend.

**When Implemented:** April 2013

**Evidence of Impact of New Processes**

Determining the impact of the changes to ECFH policies and processes from an objective perspective is difficult for several reasons. Firstly, the frequency of dangerous, violent or criminal incidents involving ECFH patients who are accessing the community or AWOL has been very low. As a result, it is essentially impossible to determine whether there have been any changes in this since the implementation of new procedures. This is further complicated by the nature of the mechanisms for reporting and recording incidents that have been in place; these are not user friendly and do not allow for the easy acquisition of information about significant events involving patients. We are not, for example, able to compare the number or frequency of AWOL incidents occurring before the changes to the number and frequency following the changes. The fact that the definition of AWOL has changed with the new
processes and that on-site smoking has led to less community access by patients also interferes with any pre- and post-changes comparisons.

It is our perception that the use of the community monitor and the automatic suspension of community access have had a significant impact on incidents of AWOLs. A survey of ECFH staff further indicates that it is staff’s belief that the new processes have reduced AWOL incidents and have enhanced our rehabilitation processes.

The following is information about AWOL incidents between April 2013 and April 2014:

There were 42 AWOL incidents during the above period; these involved 22 individual patients. 13 of these were related to the patient not following their itinerary, including six returning to hospital early, and may not have been considered an AWOL before the policy changes. Two of the AWOL patients deliberately left the jurisdiction and were gone for more than 24 hours; these were the only two for whom a media release was made. One of these patients was returned to the ECFH, the other was granted an absolute discharge after being found and dealt with by another branch of the government.

There were no known incidents of violence or criminal behaviour during any of the 42 AWOL incidents.

In seven of these incidents the patients were returned by the police; 22 returned on their own (and therefore were late rather than having attempted to abscond from the ECFH) and 12 were returned by ECFH staff. In the cases of patients returned by staff, seven of these had been patients who’d been given grounds passes only but went off hospital property within walking distance; they were retrieved by correctional staff who walked out to escort them back in. One patient was picked up by an off-duty staff member who observed him hitchhiking. The remaining four were returned by the community monitor; he found two of them and the other two called the unit with their location and the monitor was in the area and able to pick them up.

There some provisional indications that patients who’ve gone AWOL appear to have slightly higher SCAR scores than those who do not; this is an area of ongoing interest and we will continue evaluating the scale. As well, patients who have gone AWOL do not appear to have higher imminent violence risk scores (IRRS) than patients who do not go AWOL, suggesting that those accessing the community at all tend to be on the lower end of the imminent risk continuum.

Between 2005 and 2014 there were 14 incidents of problematic behaviour that staff could recall that occurred while patients were accessing the community while on a pass of some kind from ECFH. Four were physical assaults that occurred when patients were given one hour long passes that they often used to go off hospital property to smoke; these therefore occurred before the 2012 incident and any subsequent changes. None of these patients were AWOL.
These assaults were all towards other patients. There was an additional assault when a patient was on overnight passes and one when a patient was being escorted with staff to a medical appointment. The most serious incident is the one from 2012, which was when the patient was AWOL and led to a murder charge. There were five incidents of patients committing an offence such as theft or minor fraud that occurred while on community passes. There were two minor sexual offences (e.g. exposure) occurring while patients were on indirectly supervised passes; one led to charges and occurred in the community, another was just off hospital property towards another patient. Two patients were responsible for two incidents each-three property/theft offences and one assault at the area patients went to smoke.

Only the incident of 2012 occurred during an AWOL. Only one of the above violent incidents (the assault when a patient was on overnight passes) occurred when the patient was indirectly supervised in the broader community beyond hospital property.

About half of all the incidents described above led to criminal charges.

During the time period since 2005 we have had approximately 340 patients be given absolute discharges by the Nova Scotia Criminal Code Review Board; unfortunately we are not able to easily access data that provides for the number of admissions to the hospital during the same time frame because of the nature of the recording system. For further context, since 2005 there would have been literally thousands of individual occasions when patients were accessing the community independently from the hospital, particularly up until the one hour passes ended. There have been two suicides in the same time period; these individuals were either on indirectly supervised passes or overnight passes and neither were AWOL when the suicide occurred.

There have not been any violent incidents in the community while patients have been on pass since the new processes were initiated about a year ago. Given the small number of seven incidents in nine years, four of which occurred when patients were smoking just off hospital property and only one while a patient was AWOL, it is difficult to assess the impact of process changes on this type of incident in particular. Over time we will continue to collect data and work with staff and patients to refine the processes.
Appendix C


Brad Kelln, Andrew Starzomski, Jacqueline Cohen & Sara McCathie

Undated
Safety in Numbers:
New Violence Risk Management Tools
Drs. Brad Kelln, Andrew Starzomski, Jacquie Cohen, & Ms. Sarah McCathie
Clinical & Forensic Psychologists

The Background / Goals
The East Coast Forensic Hospital places an emphasis on public safety. Decisions around community access for rehabilitative patients are team-based decisions that include broad considerations of violence risk management. However, ours is a long-term facility and often patients have been on the service for many years. In such cases it is possible that clinical teams lose the focus on historical risk factors including the original offenses that brought the patient to us. To increase attention to a patient’s risk and promote examining it in a more thorough fashion, the forensic psychologists revamped and reinvented the violence risk review process from the ground up! Some of the goals of the revised process were:

- Collection of data around day-to-day violence risk variables (e.g., substance use, behaviour on unit)
- Increased, efficient communication of multiple violence risk variables
- Tying community access decisions more closely to violence risk management considerations

New Approaches
Units have a wealth of information about patients’ day to day activities but it is not always synthesized into a user-friendly format that contributes to team discussions. Borrowing from measures developed and used at the Forensic Service in Hamilton1, we created (modified):

Aggressive Incidents Scale (AIS)
The AIS allows us to code aggressive behaviour (on and off the unit) including anything from a raised voice to physical assault along with the intervention used.

Critical Behaviour Tracking Form (CBTF)
The CBTF collects all risk-relevant information in a single, monthly daily sheet. It includes AIS scores, substance use, and days spent in Locked Therapeutic Quiet (LTQ). In addition, patients’ Imminent Risk Rating Scale (IRR5) scores (tracked biweekly) are recorded here.

Structured Clinical Guide to AWOL Risk (SCAR)
Finally, patients failing to return from a community pass is always a concern (but a rare event). As a result, psychology developed a 15 item measure that helps assess the likelihood of AWOL risk. The SCAR is completed by psychology at various intervals.

Patient Risk Summary
With the new scales, the ECFH now tracks a number of new, and important, violence-risk-related variables but we needed something else. The Patient Risk Summary (PRS) is a unique document designed by psychology that captures all risk measures and current behaviour along with a summary of:

- Patient’s index offence (why they’re in hospital)
- Patient’s violent criminal history (if any)
- Past victims
- Non-charged violence (e.g., in hospital)
- Medication non-compliance
- Factors identified in formal risk assessment including comment on current management
- Any recent AWOLs
- Current SCAR, AIS, and IRRS scores

It is now mandatory that the PRS be updated and reviewed during each and every team meeting where community access changes are contemplated by the ECFH. The inclusion of an updated PRS is required along with the paperwork for community access changes sent to management.

Ongoing Evaluation
Since September we have been collecting data and ongoing efforts at evaluation and analysis continue with preliminary results offering positive findings (e.g., SCAR scores are associated with AWOLs).
Appendix D

“ECFH Processes Related to Community Access”

No author listed - Undated

Received at May 21, 2014 meeting between members of the Health Law Institute and staff at the ECFH
Appendix D – East Coast Forensic Hospital Processes Related to Community Access

The rehabilitation units at the ECFH house up to 60 individuals who have either been found unfit to stand trial or not criminally responsible due to mental disorder (NCR) for their offences by the court. These individuals, legally known as ‘accused’ but referred to by us as patients or clients, then enter what is informally called the forensic psychiatric/mental health system and fall under the jurisdiction of the Criminal Code Review Board, which in Nova Scotia is referred to as the Nova Scotia Review Board (“the Board”).

The rehabilitation units are where all detained NCR/unfit patients reside; as a result we have patients who may be at very different points in their rehabilitation and community reintegration. Some patients have been in hospital and with the ECFH service for many years whereas others may have just arrived after having been recently found NCR/unfit. The range of lengths of stay is quite wide; some patients may receive an absolute discharge at their first Board hearing whereas others remain in hospital for years.

All new in custody NCR patients (this document will refer only to NCR patients as they are the vast majority of our patients), if not granted a disposition by the Court are meant to be reviewed by the Board within 45 days. If they are already in custody and had their court ordered assessment done in the Mentally Ill Offender Unit they will then be transferred to the rehab unit and remain in custody. If they were already in the community because they had not been remanded they will, almost always, remain in the community.

New NCR patients do not normally have any access to the community before their first (initial) hearing unless it is supervised by staff and for a specific purpose such as a necessary medical appointment or a personal matter that needs to be addressed in person and may be time sensitive. Prior to the review of 2012 we would ask the Board for some patients to be able to have indirectly supervised community access before their full initial hearing and this was frequently granted. Getting this access was often pursued by defence counsel on their client’s behalf. This practice was stopped after the review as per its recommendations. We had not had any AWOL’s committed by patients using those passes but the absence of the Board having seen the risk assessment and formally reviewing the patients’ case led to the recommendation to cease these passes.

When new NCR patients are admitted to rehab they are assigned a clinical team consisting of a psychiatrist, psychologist, prime nurse, social worker, occupational therapist and a forensic case coordinator. There is also a recreation therapist and a spiritual care clinician who are involved with all patients and many learners from every discipline. The focus on the first month of the patient’s admission to rehab is preparing for the initial review board hearing; a report comprised of information from some or all of the disciplines is prepared for the Board to assist
it with its primary mandate, to determine whether the patient poses a significant threat to the safety of the public. The report usually includes extensive background information, including past criminal record, a review of the index offence(s), current mental status and treatment to date, a risk assessment and usually an opinion from the team regarding significant threat and a recommendation on disposition.

The risk assessment is usually conducted by psychology and is done using well established and validated tools meant to assess an individual’s long term risk of violent reoffending. Long term refers to the risk of violent reoffending over several years. Long term risk is primarily assessed based on historical, static (and therefore unchangeable) information about the patient. We do not assess dangerousness as a broad concept. The risk assessment tools include the Psychopathy Checklist Revised (PCL-R), the actuarial risk assessment instrument the Violence Risk Appraisal Guide (VRAG) and the structured professional judgement tool, the Historical-Clinical-Risk 20 (HCR-20). The report for the Board provides an opinion of the patient’s floor level of long term risk of violent reoffending—essentially the lowest level it can ever be—in a composite manner—low, medium or high—and their current level of risk, based on the status of relevant dynamic, i.e. changeable, risk factors.

The team presents the report and its opinion and recommendations to the Board. We also usually present a general plan for the patient’s rehabilitation, treatment and community reintegration, if appropriate, at the hearing. The detail and nature of this will be highly variable and dependent to a great extent on the patient’s mental state, history and risk level.

If the Board determines that the patient is a significant threat to the safety of the public and the person needs to be detained in the hospital they will usually set the ceiling of community access for the patient at its maximal level, which is up to 6 overnights in the community per week. The next hearing does not have to be for a year so this is done to provide maximal flexibility to the team; the Board tends to not want to be involved in micromanaging the patients’ community access and defers to the hospital in this regard. Occasionally they do not do this and set a lower ceiling of community access so that the team has to return to the Board when a greater amount of community access is requested.

The Board is not given any formal information about the patient’s possible AWOL risk and they do not request this information. They are advised, in subsequent reports, about any AWOL’s committed by patients since the previous hearing.

There have not been any incidents of violent or general reoffending committed by AWOL patients during the past several years other than the one of April 2012. There has not been any violent or general reoffending, to our knowledge, committed by patients who were on a community access pass or who were residing in the community on a conditional discharge. Any violent reoffending, whether it led to criminal charges or not, has occurred either in hospital-between patients or towards staff—or, in the past, at the spot patients would go to to smoke that was just off hospital property.
After the initial hearing and the disposition is received and the community access ceiling known, the clinical team begins planning for the patient’s rehabilitation, if needed. While they are in hospital nursing staff rate patients on the Imminent Risk Rating Scale (IRRS) on a variable frequency. This examines the patient’s short term risk of violence; the rating is reported at weekly update meetings where all patients are discussed and is reviewed as part of the Patient Risk Summary (PRS).

When the clinical team determines that the patient is ready to begin having community access they meet to review the patient’s current status re: conduct in hospital (whether they are following rules and expectations), mental state, whether there’s been any substance use, participation in programming, recent IRRS scores, updated SCAR (Structured Clinical Guide to AWOL Risk) score, Aggressive Incidents Scale (AIS), Critical Behaviour Tracking Form and the goals and purpose of community access.

At that meeting a Community Access Request form is completed and includes all the above information and other relevant details. Team members sign it and it is then passed on to the Community Access Oversight Committee for review and approval (or not) and then it goes to the ECFH program leader and then ‘administrator in charge of the hospital’ who in practice is the Director of the Capital Health Addictions and Mental Health Program. After all required approvals are received the form returns to the rehab unit, is placed in the patient’s chart and only at that point can a doctor’s order be written for the patient to have community access.

We have a system of different levels of community access that ranges from directly supervised access to complete discharge. Within most levels, in particular directly and indirectly supervised access and overnight passes, the duration and frequency of passes can be increased as required and felt to be appropriate and necessary by the clinical team, without having to complete another community access request form. The community access request process is about beginning the passes and then moving between levels. A meeting and new form is completed each time a request to move between community access levels is being done. This can include going up one or more levels or formally reducing the patient’s community access. Almost all patients begin with directly supervised passes and then progress to increasing amounts of community access as is warranted and required. The rate of progress is highly variable and can be adjusted or stopped at any time as circumstances dictate.

Before going out on an indirectly supervised pass all patients are assessed by nursing staff - mental status, discussion of plans and itinerary and nursing staff have the authority to hold passes if they have any type of concern about the patient-this could include an altered mental state or suspicions about AWOL risk or other conduct issues, such as the possibility that the patient is going to bring back contraband.

When patients begin having indirectly supervised passes the following option are available for monitoring their passes:
Use of itineraries: patients may be required to provide a detailed itinerary of their pass plans, with locations of where they are going and times of arrival and departure. Not adhering to the itinerary without advance notice is considered an AWOL incident.

Community monitor: ECFH staff person who goes out into the community to check on patients as per their itinerary.

Cell phone: patients either have their own cell phone or are provided one by staff to take on pass in order to call in any changes or issues or to be reached if necessary.
Appendix E

Select Charter Sections
Appendix E – Select Charter Sections

Guarantee of Rights and Freedoms

Rights and freedoms in Canada

1. The Canadian Charter of Rights and Freedoms guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

Legal Rights

Life, liberty and security of person

7. Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

Search or seizure

8. Everyone has the right to be secure against unreasonable search or seizure.

Detention or imprisonment

9. Everyone has the right not to be arbitrarily detained or imprisoned.

Treatment or punishment

12. Everyone has the right not to be subjected to any cruel and unusual treatment or punishment.

Equality Rights

Equality before and under law and equal protection and benefit of law

15. (1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

Affirmative action programs

(2) Subsection (1) does not preclude any law, program or activity that has as its object the amelioration of conditions of disadvantaged individuals or groups including those that are disadvantaged because of race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.
Appendix F

Select Nova Scotia

*Human Rights Act Sections*
Appendix F – Select Nova Scotia *Human Rights Act* Sections

**Meaning of discrimination**

4 For the purpose of this Act, a person discriminates where the person makes a distinction, whether intentional or not, based on a characteristic, or perceived characteristic, referred to in clauses (h) to (v) of subsection (1) of Section 5 that has the effect of imposing burdens, obligations or disadvantages on an individual or a class of individuals not imposed upon others or which withholds or limits access to opportunities, benefits and advantages available to other individuals or classes of individuals in society.

**Prohibition of discrimination**

5 (1) No person shall in respect of

(a) the provision of or access to services or facilities;

(b) physical disability or mental disability;

**Exceptions**

6 Subsection (1) of Section 5 does not apply

(f) where a denial, refusal or other form of alleged discrimination is

(i) based upon a bona fide qualification,

(ia) based upon a bona fide occupational requirement; or

(ii) a reasonable limit prescribed by law as can be demonstrably justified in a free and democratic society;

or

(i) to preclude a law, program or activity that has as its object the amelioration of conditions of disadvantaged individuals or classes of individuals including those who are disadvantaged because of a characteristic referred to in clauses (h) to (v) of subsection (1) of Section 5.

**Exemption by Commission**

9 Notwithstanding anything in this Act, the Commission may exempt a program or activity from subsection (1) of Section 5, or a part thereof, where, in the opinion of the Commission, there is a bona fide reason to do so.