

**SUPREME COURT OF CANADA**

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| **Citation:** R. v. Conception, 2014 SCC 60, [2014] 3 S.C.R. 82  | **Date:** 20141003**Docket:** 34930 |

Between:

Brian Conception

Appellant

and

Her Majesty The Queen, Person in Charge of the Centre for Addiction and Mental Health and Person in Charge of the Mental Health Centre Penetanguishene

Respondents

- and -

Attorney General of Canada, Attorney General of Quebec, Criminal Lawyers’ Association of Ontario and Mental Health Legal Committee

Interveners

**Coram:** McLachlin C.J. and LeBel, Abella, Rothstein, Cromwell, Moldaver, Karakatsanis, Wagner and Gascon JJ.

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| **Joint Reasons for Judgment:**(paras. 1 to 44)**Concurring Reasons:**(paras. 45 to 133) | Rothstein and Cromwell JJ. (LeBel, Abella and Gascon JJ. concurring)Karakatsanis J. (McLachlin C.J. and Moldaver and Wagner JJ. concurring) |

r. *v.* conception, 2014 SCC 60, [2014] 3 S.C.R. 82

Brian Conception Appellant

v.

Her Majesty The Queen,

Person in Charge of the Centre

for Addiction and Mental Health and

Person in Charge of the Mental Health

Centre Penetanguishene Respondents

and

Attorney General of Canada,

Attorney General of Quebec,

Criminal Lawyers’ Association of Ontario and

Mental Health Legal Committee Interveners

**Indexed as: R. *v.* Conception**

2014 SCC 60

File No.: 34930.

Hearing: October 17, 2013.

Present: McLachlin C.J. and LeBel, Abella, Rothstein, Cromwell, Moldaver, Karakatsanis and Wagner JJ.

Re‑hearing ordered:  July 30, 2014.

Judgment:  October 3, 2014.

Present: McLachlin C.J. and LeBel, Abella, Rothstein, Cromwell, Moldaver, Karakatsanis, Wagner and Gascon JJ.

on appeal from the court of appeal for ontario

 *Criminal law — Mental disorder — Dispositions by a court or review board — Treatment disposition — Accused declared unfit to stand trial — Hearing judge issuing a “forthwith” treatment order without consent of treating hospital — Whether a court may make a disposition order directing that treatment begin immediately even though the hospital or treating physician does not consent to that disposition — Whether the consent requirement relates to the timing of carrying out the order or just to the treatment itself — Criminal Code, R.S.C. 1985, c. C‑46, ss. 672.58, 672.62(1)(a).*

 *Constitutional law — Charter of Rights and Freedoms — Right to life, liberty and security of the person — Criminal law — Mental disorder — Treatment disposition — Whether requiring hospital’s consent for all provisions of the treatment disposition would infringe accused’s right to procedural fairness — Whether treatment disposition provisions of Criminal Code are unconstitutionally vague or arbitrary — Charter of Rights and Freedoms, s. 7 — Criminal Code, R.S.C. 1985, c. C‑46, ss. 672.58, 672.62(1)(a).*

 C was charged with sexual assault. When he appeared in court, he was in a psychotic state and was declared unfit to stand trial. Crown counsel recommended a treatment order. The Crown stated that a bed would be available in a facility at one hospital six days after the hearing. The hearing judge issued a “forthwith” treatment order, specifying C be treated at a second hospital or its “designate” (preferably the facility at the first hospital). Court services delivered C to the first hospital and left him in a hallway. The hospitals appealed this decision. The Court of Appeal held that the hearing judge erred by acting on the basis that the consent requirement of the *Criminal Code* provision relating to treatment had been satisfied. The Court of Appeal also determined that the applicable provisions of the *Criminal Code* (ss. 672.58 and 672.62(1)(*a*)) engage the rights to liberty and security of the person guaranteed under s. 7 of the *Charter*, but do not violate the principles of fundamental justice.

 *Held*:The appeal should be dismissed.

 *Per* LeBel, Abella, Rothstein, Cromwell and Gascon JJ.: Consent is required for the disposition order in its entirety, not simply to the treatment aspect of it. A court may not make a disposition order directing that treatment begin immediately if the hospital or treating physician does not consent to that disposition unless the situation is a rare case in which a delay in treatment would breach the accused’s rights under the *Canadian Charter of Rights and Freedoms* and an order for immediate treatment is an appropriate and just remedy for that breach.

 The hospital or person in charge of treatment must consent to all the terms of a disposition ordering treatment and, if there is no consent, the order cannot be made. The starting point is the text of the provisions in their grammatical and ordinary sense according to the modern principle of statutory interpretation. The *Criminal Code* provides that no court shall make a “disposition” under s. 672.58 without the consent of the hospital or person in charge of treatment. “Disposition” is a technical term, used throughout Part XX.1. While a disposition ordering treatment may be referred to as a “treatment order” in colloquial language, there is no such thing provided for in the *Criminal Code.* It is clear that a “disposition” under s. 672.58 necessarily has a temporal aspect both as to its beginning and its ending and may include other conditions that the court considers it appropriate to impose. Thus consent is required to the disposition which the court makes under s. 672.58, not simply to certain aspects of it. This is supported by the meaning of the word “consent” and the context in which it is used in these provisions. Where the *Criminal Code* intends to differentiate between consent to treatment and consent to a disposition order, it does so expressly.

 An order under s. 672.58 is extraordinary in that it directs that treatment of an accused be carried out without the accused’s consent and by necessary implication, it authorizes medical personnel to carry out that treatment against the accused’s wishes. The provisions recognize the importance of the treatment provider’s clinical judgment, not only as to the particular treatment but as to the location at which it is to be carried out. This broad understanding of the scope of the required consent is reinforced by the practical realities of providing involuntary treatment to potentially dangerous individuals. The timing of a treatment order for an accused who has been found unfit to stand trial must be an element of the hospital’s consent because, from the hospital’s perspective, the time at which treatment is to be provided is inextricably linked to the hospital’s ability to provide treatment safely and effectively. The ability of the hospital to administer the suitable treatment is inextricably linked to whether it has the facilities and personnel available to do so. Timing is therefore an essential element of suitability and not distinct from it. Consent under s. 672.62(1) of the *Code* must therefore include timing.

 The consent requirement does not deprive the accused of procedural fairness and is not unconstitutionally vague or arbitrary. Any potential violation of s. 7 rights would result from the exercise of the hospital’s discretion to withhold consent in a particular case, and is not inherent in the section itself. No such breach was established in this case. That said, a judge proposing to make a disposition is entitled to consider, in an appropriate case, whether a refusal of consent will have the effect of unconstitutionally limiting the accused’s rights to life, liberty or security of the person in a fashion that does not accord with the principles of fundamental justice. If so persuaded, the judge would be entitled to consider whether ordering an immediate admission would constitute an appropriate and just remedy for that breach.

 *Per* McLachlin C.J. and Moldaver, Karakatsanis and Wagner JJ.: The treatment order regime in Part XX.1 of the *Criminal Code* is intended to bring mentally ill accused persons to the cognitive threshold required to proceed to trial. A court’s discretion under s. 672.58 to order treatment to render an individual fit for trial is subject to stringent safeguards and timelines. Given the potential for involuntary medical treatment, one such safeguard is the requirement for hospital consent set out in s. 672.62(1)(*a*). However, when the consent requirement is read in its proper statutory context, it is clear that hospital consent is not required to all the terms and conditions of the treatment order. The hospital’s consent is required only to the treatment itself. Bed shortages and patient wait lists do not permit a hospital to refuse, or defer, consent. Consent may be withheld only for medical reasons and cannot be withheld on the basis of efficient management of hospital resources.

 Treatment orders seek to render the accused fit to stand trial, in order to protect the rights to a timely trial and procedural fairness, as well as to safeguard the public interest in accused persons standing trial. They also serve to ensure that the accused’s liberty is minimally impaired. While the medical and legal interests of accused persons are both at stake, the ultimate purpose of treatment orders is to protect the legal interests of the accused.

 Interpreting the provisions in light of (1) the purposes of Part XX.1, the treatment order regime and the consent requirement, (2) the scheme of strict judicial control and oversight with strict timelines, and (3) the appeal and automatic stay provisions, the requirement for hospital consent relates only to a hospital’s willingness to deliver a particular treatment. Requiring hospital consent to all terms of a treatment “disposition” would effectively give them a broad veto over whether a treatment order could be issued, without regard to the accused’s legal interests. If hospitals may refuse consent, or dictate the timing of a treatment order, for any reason, including its internal operations and wait lists, it would be a significant derogation from Part XX.1’s comprehensive scheme of judicial controls and tight timelines. Only judges will be able to assess the risks that would flow from failing to immediately treat an unfit accused because many of the greatest dangers will result not from the “medical urgency” of this treatment as seen by hospitals, but rather from the risks that such an accused would face in jail. Furthermore, the automatic stay of a treatment order upon appeal by the institution would be meaningless if the treatment order could not be issued absent hospital consent to all its terms and conditions. Rather, the scheme provides a stay and contemplates a hospital appeal precisely because certain “conditions” of the treatment order ― including the timing ― are decided by the court.

 Thus while bed shortages are not a basis for the hospital to refuse consent, they are part of the circumstances in which the judge exercises her discretion in deciding the start date of a treatment order. If the hospital is concerned about bed unavailability, or its ability to safely carry out the treatment immediately, the discussion about triage can take place before the judge. In setting the start date for treatment, the judge will consider bed shortages, but she does so along with the liberty, security and procedural fairness interests of the accused, as well as assessing the impact on the accused of waiting in jail and the delays to the trial. If the court attaches what the hospital considers to be unreasonable conditions to a treatment order, the hospital may exercise its statutory right of appeal, and benefit from the automatic stay.

 The Court of Appeal was correct in deciding that the “forthwith” order in this case should not have been issued; however, this is not because the trial judge lacked jurisdiction to issue a treatment order. Rather, the hearing judge’s decision regarding the timing of the treatment order was not reasonable.

**Cases Cited**

By Rothstein and Cromwell JJ.

 **Referred to:** *Winko v. British Columbia (Forensic Psychiatric Institute)*, [1999] 2 S.C.R. 625; *Mazzei v. British Columbia (Director of Adult Forensic Psychiatric Services)*, 2006 SCC 7, [2006] 1 S.C.R. 326.

By Karakatsanis J.

 **Referred to:** *R. v. R.R.*, 2006 ONCJ 141 (CanLII); *R. v. Consuelo*, Ont. Ct. J., Toronto, Nos. 10‑10001715, 10‑10004017, 10‑70009469, September 14, 2010 (unreported); *R. v. Procope*, Ont. Ct. J., Toronto, Nos. 10009107, 1200160, October 6, 2010 (unreported); *Centre for Addiction and Mental Health v. Al‑Sherewadi*, 2011 ONSC 2272, [2011] O.J. No. 1755 (QL); *Mazzei v. British Columbia (Director of Adult Forensic Psychiatric Services)*, 2006 SCC 7, [2006] 1 S.C.R. 326; *Penetanguishene Mental Health Centre v. Ontario (Attorney General)*, 2004 SCC 20, [2004] 1 S.C.R. 498; *Winko v. British Columbia (Forensic Psychiatric Institute)*, [1999] 2 S.C.R. 625.

**Statutes and Regulations Cited**

*Canadian Charter of Rights and Freedoms*, s. 7.

*Criminal Code*, R.S.C. 1985, c. C‑46, Part XX.1, ss. 672, 672.1 “disposition”, 672.11, 672.12, 672.13(1), 672.14, 672.23, 672.29, 672.46, 672.5(2), 672.54, 672.58, 672.59, 672.6, 672.61, 672.62, 672.63, 672.72, 672.75, 672.93.

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 APPEAL from a judgment of the Ontario Court of Appeal (Simmons, Blair and Hoy JJ.A.), 2012 ONCA 342, 111 O.R. (3d) 19, 259 C.R.R. (2d) 286, 292 O.A.C. 20, 94 C.R. (6th) 405, 284 C.C.C. (3d) 359, [2012] O.J. No. 2253 (QL), 2012 CarswellOnt 6369, setting aside a treatment disposition of Hogan J. Appeal dismissed.

 *Frank Addario* and *Paul Burstein*, for the appellant.

 *Riun Shandler*, *Grace Choi* and *Dena Bonnet*, for the respondent Her Majesty The Queen.

 *Jonathan C. Lisus*, *Eric R. Hoaken* and *Ian C. Matthews*, for the respondent the Person in Charge of the Centre for Addiction and Mental Health.

 *James P. Thomson* and *Janice E. Blackburn*, for the respondent the Person in Charge of the Mental Health Centre Penetanguishene.

 *Richard Kramer* and *Ginette Gobeil*, for the intervener the Attorney General of Canada.

 *Dominique A. Jobin* and *Caroline Renaud*, for the intervener the Attorney General of Quebec.

 *Jill R. Presser* and *Anita Szigeti*, for the intervener the Criminal Lawyers’ Association of Ontario.

 *Suzan E. Fraser* and *Mercedes Perez*, for the intervener the Mental Health Legal Committee.

 The judgment of LeBel, Abella, Rothstein, Cromwell and Gascon JJ. was delivered by

 Rothstein and Cromwell JJ. —

1. Introduction
2. When an accused person has been found unfit to stand trial and the other statutory requirements have been met, the court may make a disposition order directing that treatment be carried out for a specified period not exceeding 60 days and on such conditions as the judge considers appropriate for the purpose of making the accused fit to stand trial. The disposition order may not be made, however, without the consent of either the person in charge of the hospital where the accused is to be treated or the person to whom responsibility for the treatment of the accused has been assigned. (For ease of reference, we will refer to this as the hospital’s consent.)
3. The main issue on appeal is whether, as the appellant contends, the court may make a disposition order directing that treatment begin immediately even though the hospital or treating physician does not consent to that disposition. In our view, the answer to this question is “no” in all but the rare case in which a delay in treatment would breach the accused’s rights under the *Canadian Charter of Rights and Freedoms*, and an order for immediate treatment is an appropriate and just remedy for that breach.
4. Thus, while we would dismiss the appeal, we respectfully disagree with our colleague Karakatsanis J. that the hospital’s consent relates only to the treatment ordered in the disposition and not to the disposition order itself. As we see it, that reading of the relevant provisions of the *Criminal Code*, R.S.C. 1985, c. C-46, cannot be reconciled with its unambiguous text. The *Code* specifically distinguishes between consent to treatment and consent to the disposition and explicitly requires that a disposition may not be made without the hospital’s consent. The hospital consent is required for the disposition order in its entirety, not simply to the treatment aspect of it. Read any other way, the appeal provisions relating to dispositions are incoherent. Moreover, the interpretation that we favour is consistent with the purpose of the scheme and the broader context in which it exists.
5. The specific provisions of the *Criminal Code* dealing with UST accused that are relevant to this appeal are ss. 672.58 and 672.62. As we shall see, these provisions make clear that while the court may not make a disposition — which may include not only the treatment, but also the period of treatment and other conditions which the court considers appropriate — without the hospital’s consent, the accused’s consent is dispensed with in relation *only* to the treatment to “be carried out pursuant to a disposition”.

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

 **672.62** (1) [Consent of hospital required for treatment] No court shall make a disposition under section 672.58 without the consent of

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

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

 (2) [Consent of accused not required for treatment] The court may direct that treatment of an accused be carried out pursuant to a disposition made under section 672.58 without the consent of the accused . . . .

Other relevant provisions referred to in these reasons are set out in the Appendix.

1. Facts, Proceedings and Issues
2. The appellant was charged with sexual assault. When he appeared in court, he was in a psychotic state and was declared unfit to stand trial (“UST”). Crown counsel recommended a treatment order. When asked about security concerns, a psychiatrist testified that treatment at Oak Ridge, a facility at the Mental Health Centre Penetanguishene (“MHCP”), would make more sense than the Centre for Addiction and Mental Health (“CAMH”), another hospital with which he had experience. The Crown stated that a bed would be available at Oak Ridge no later than the 19th of April which was six days after the date of the hearing. The hearing judge, Hogan J., issued a “forthwith” treatment order pursuant to s. 672.58 of the *Criminal Code* directing that the appellant shall be treated at “CAMH or designate (preferably Oakridge [*sic*]”, he shall remain in custody at “CAMH or designate”, and he shall “be taken directly from court to the designated hospital and from hospital directly back to court” and not to “a jail or correctional facility under any circumstances” (A.R., vol. I, at p. 2).
3. Reasons for judgment were not issued but during the proceedings, the hearing judge said:

When I made a determination that as of today this individual needs to have a treatment order[,] I have based that on expert psychiatric opinion. I would be negligent and derelict in my duty and my responsibilities [i]f I were to say, well it is okay, he has — you know he is the subject of a treatment order which I consider to be an extreme measure . . . .

. . .

 . . . I make orders that people [are] against sometimes, not always, but essentially against their will have drugs administered to them. That is extraordinarily serious and we do that because we feel it is absolutely necessary and that means now, not a week from now and I understand that, as I said, and I do not do it lightly when I do things like this, but I understand it does create disruption. But, you know, it would probably be better if he is in a bed in the hall of a psychiatric hospital than if he is in the medical unit not getting what I have been told is absolutely necessary treatment for, you know, a week.

. . .

 . . . if it is okay to have him wait a week then we should not be asking for treatment orders today and I should not be making them; it is not okay.

. . .

 . . . if we are prepared to do something as serious as make treatment orders and then say, but it is okay they can sit in a jail bed. That is not appropriate. We have a mental health system here that is supposed to treat people and you know ordering treatment orders is one of the most serious things we can do in terms of the mental health system and yet we cannot seem to provide a bed for them to get treated in and that is totally unacceptable. And I understand the argument but it is not an argument that carries any weight with me . . . .

. . .

 . . . I am prepared to be flexible where he goes as long as it is a hospital. I know Oak Ridge is preferable but in these circumstances I can be flexible about that.

 . . . so if I say CAMH or designate; I will ask that the order say preferably Oak Ridge, but I think getting him to a hospital at least, initially, is probably the most important thing . . . . [A.R., vol. I, at pp. 7-11]

1. Court services delivered the appellant to the Mental Health Centre Penetanguishene and left him in a hallway.
2. The respondent hospitals appealed the timing aspect of the disposition under s. 672.72(1) which provides for appeals “against a disposition . . . by a court”. (We note that if the appellant is right that a “disposition” does not include timing, there would be no right of appeal of the timing aspect of the disposition order under this provision. No one has ever taken this position.) Notwithstanding that the appellant thereafter was treated, eventually returned to court, and the charge was stayed by the time the appeal began, the Court of Appeal proceeded to determine that ss. 672.58 and 672.62(1)(*a*) of the *Criminal Code* engage the rights to liberty and security of the person guaranteed under s. 7 of the *Charter*, but do not violate principles of fundamental justice.
3. The Court of Appeal held that Hogan J. erred by acting on the basis that the consent requirement had been satisfied. It held that there was never any doubt that CAMH or its designate, MHCP, would admit the appellant. It noted that a memorandum of understanding between CAMH and 102 Mental Health Court provided a form of general consent to the placement and treatment of accused persons. It held that this memorandum implicitly provided that hospitals would have the necessary facilities, personnel, and resources for effective and safe treatment. It held that this implied that admission would be withheld when a bed was not available for safety reasons. It held that consent to treat a patient when a bed becomes available is not consent to accept a patient forthwith.
4. The Court of Appeal accepted that a mentally unfit accused person’s right to liberty and security of the person is engaged but that the consent requirement in s. 672.62(1)(*a*) does not violate the principle of fundamental justice requiring procedural fairness because the consent requirement responds to a general reluctance in law to compel a medical practitioner or hospital authorities to administer treatment; it responds to the common law’s unwillingness to compel someone to submit involuntarily to medical treatment by assuring that “the treatment order process is initiated and . . . likely to produce positive results” (para. 52); it responds to the significant risks to patients and to medical personnel, hospital staff and others when potentially violent psychotic patients are detained in settings where proper facilities are not available; and it permits Ontario’s forensic psychiatric facilities to co-operate in triaging the needs of UST and NCR accused, matters not within the knowledge of the courts. The Court of Appeal concluded that it is not unreasonable that a UST accused may have to wait on some occasions for a short period of time until a bed becomes available in a designated psychiatric facility and there was no evidence that a six-day delay in starting treatment might impair the likelihood of the appellant becoming fit to stand trial.
5. The Court of Appeal also held that s. 672.62(1)(*a*) is not void for vagueness or arbitrariness.
6. On the further appeal to this Court, the appellant raises two main questions concerning the scope of the hospital’s required consent:

Does the consent requirement relate to the timing of carrying out the order or just to the treatment itself?

If the consent requirement relates to the timing of carrying out the order, does the s. 672.58 order violate s. 7 of the *Charter*?

1. Analysis
	1. Does the Consent Requirement Relate to Timing?
		1. The Approach to Statutory Interpretation
2. In our view, the meaning of the relevant provisions, supported by an understanding of their full context, leads to the conclusion that the hospital or person in charge of treatment must consent to all the terms of a disposition ordering treatment and, if there is no consent, the order cannot be made. The terms of the order include when it is to be carried out and therefore consent relates to timing.
3. This issue raises a question of statutory interpretation which must be resolved according to the modern principle of statutory interpretation: “the words of an Act are to be read in their entire context, in their grammatical and ordinary sense harmoniously with the scheme of the Act, the object of the Act, and the intention of Parliament” (R. Sullivan, *Sullivan on the Construction of Statutes* (5th ed. 2008), at p. 1, citing E. A. Driedger, *The Construction of Statutes* (1974), at p. 67). We underline that the starting point is the text of the provisions in their grammatical and ordinary sense. This is especially the case where, as here, the key term “disposition” is expressly defined in the statute. In our view, the appellant fails to do this.
	* 1. Statutory Context and Statutory Text
4. It is helpful to begin by putting the most relevant provisions in their wider statutory context. The relevant provisions are found within Part XX.1 of the *Code* which deals with mental disorder. The twin purposes of this Part of the *Code* are protection of the public and fair treatment, in the sense of procedural fairness, of the accused: *Winko v. British Columbia (Forensic Psychiatric Institute)*, [1999] 2 S.C.R. 625, at paras. 20, 21 and 44; see also *Mazzei v. British Columbia (Director of Adult Forensic Psychiatric Services)*, 2006 SCC 7, [2006] 1 S.C.R. 326, at para. 27.
5. The *Code* provides that no court shall make a “disposition” under s. 672.58 without the consent of the hospital or person in charge of treatment. The provisions respecting “dispositions” are central to the legislative scheme set out in Part XX.1 of the *Code.* Several provisions give both a court and a Review Board the authority to make various dispositions in relation to persons falling within the ambit of Part XX.1. Under the scheme, courts reach a “verdict” (respecting fitness to stand trial and criminal responsibility), both courts and Review Boards make a “disposition” (in relation to persons found UST and not criminally responsible) and Review Boards make a “placement decision” (with respect to a “dual status offender”, that is, a person who is both serving a sentence of imprisonment and is subject to a custodial disposition under Part XX.1).
6. The key point is that “disposition” is a technical term, used throughout Part XX.1. While a disposition ordering treatment may be referred to as a “treatment order” in colloquial language, there is no such thing provided for in the *Code.*  “Disposition” is a defined term. In the context of dispositions made by courts, a “disposition” is defined by s. 672.1 as meaning “an order made by a court” under s. 672.54 or s. 672.58, the latter being the provision that concerns us here.
7. As s. 672.58 makes clear, a “disposition” ordering treatment under that section necessarily includes aspects relating to timing: it *must* set out a “specified period not exceeding sixty days” and it may be made “subject to such conditions as the court considers appropriate”, including presumably conditions related to timing. Moreover, a disposition comes into force on the day on which it is made or on any later day that the court specifies: s. 672.63.
8. All of this makes it clear that a “disposition” under s. 672.58 necessarily has a temporal aspect both as to its beginning and its ending and may include other conditions that the court considers it appropriate to impose.
9. The *Code* provides that “[n]o court shall make a disposition under section 672.58 without the consent of (*a*) the person in charge of the hospital where the accused is to be treated; or (*b*) the person to whom responsibility for the treatment of the accused is assigned by the court”: s. 672.62. At paragraph 109, our colleague suggests that s. 672.62 provides for hospital consent with respect to only the “treatment” aspect of the disposition, and not the “disposition” generally. With respect, this is not how we read s. 672.62. If “[n]o court shall make a disposition . . . without . . . consent”, then the consent relates to the disposition. Further, as just discussed, a “disposition under section 672.58” necessarily has a temporal element. The hospital must consent to the “disposition”; there is nothing in the text to suggest that this requirement should be given anything other than its defined meaning in the *Code*. Consent is required to a “disposition” and “disposition” is defined to mean “an order made by a court under section 672.58”: s. 672.1. Thus the hospital’s consent is required to the disposition which the court makes under s. 672.58, not simply to certain aspects of it.
10. This conclusion is supported by the meaning of the word “consent” and the context in which it is used in these provisions.
11. The ordinary meaning of the word “consent” in the context of medical treatment is understood to be voluntary agreement to a medical course of action made with an appreciation of all material information and risks. The starting date of treatment is a material fact, going to the availability of the necessary bed and staff ready to execute the treatment order safely.
12. The context in which the word “consent” is used in this scheme supports this broad understanding of the term. Where the *Code* intends to differentiate between consent to treatment and consent to a disposition order, it does so expressly. For example, in s. 672.62, subsection 1 deals with the hospital’s consent to “a disposition” whereas subsection 2 deals with the accused’s consent to “treatment . . . pursuant to a disposition”. Had the intention been to simply require the hospital’s consent to the proposed treatment, language similar to that used in subsection 2, which links consent only to the treatment, could have made that intent clear. Instead, subsection 1 links the hospital’s consent to the “disposition” not merely to the “treatment of an accused . . . carried out pursuant to a disposition” as in subsection 2. This demonstrates that Parliament, which took care to define the term “disposition”, used the term in its defined sense — as it did in relation to hospital consent under s. 672.62(1) — and used different language to refer only to the treatment component of a disposition — as it did in relation to the accused’s consent in s. 672.62(2).
13. Given that “disposition” is a defined term meaning the “order made by a court under section 672.58” and the *Code* explicitly requires the hospital’s consent to a disposition under that section, we see no possible ambiguity in the text of these provisions. Any possible doubt is dispelled by the clear distinction in s. 672.62 between, on the one hand, the hospital’s consent to the “disposition” which is required under s. 672.62(1) and, on the other hand, the accused’s consent to “treatment . . . carried out pursuant to a disposition” which is not required. We do not see how Parliament could have more clearly expressed its intent that the hospital’s consent in s. 672.62(1) relates to all the provisions of the disposition, including when treatment will begin as well as what is to be done.
14. Our colleague Karakatsanis J. reads the appeal provisions in Part XX.1 as supporting the appellant’s view that consent to a disposition order does not require consent to the timing aspects of the disposition order. We respectfully disagree. As we see it, the interpretation that we propose is reinforced, not weakened, by the appeal provisions in Part XX.1. Under s. 672.72(1), “[a]ny party may appeal against a disposition made by a court . . . on any ground of appeal that raises a question of law or fact alone or of mixed law and fact.” This, of course, is the provision that allowed the hospital in this case to appeal the judge’s “forthwith” disposition order. However, the appellant contends that the “disposition” under s. 672.58 does not include the timing of the treatment which is ordered. It follows that, on the appellant’s reading of the *Code*, the term “disposition” means something different in ss. 672.58 and 672.62 than it does in s. 672.72. If, as the appellant contends, consent to a “disposition” as required by s. 672.62 does not require consent as to timing of treatment, it must follow that an appeal under s. 672.72 from a “disposition” cannot relate to the timing of the treatment either. Respectfully, this simply cannot be the case. “Disposition” is a defined term: it means an “order made by a court under section 672.58”. The term “disposition” must bear this meaning everywhere it is used in Part XX.1 of the *Code.* The appellant offers no explanation as to why the express definition of the term applies in the appeal provisions but not in the treatment disposition provisions even though both the consent requirement and the right of appeal relate to a disposition under s. 672.58.
15. We also, respectfully, cannot agree that if the hospital’s consent were required to the timing aspect of a disposition, there would be no point in providing the hospital with a right of appeal as it could simply refuse to consent. This case shows that this line of argument is incorrect. The appeal process under Part XX.1 permitted the judge’s forthwith order in this case to be appealed and her legal error in making it to be corrected on appeal.
16. The appellant argues that consent in relation to a s. 672.58 disposition order must not include timing because the institutions do not have any right to refuse to accept immediately patients on other court-ordered placements as, for example, under s. 672.11 (psychiatric assessments) and s. 672.54(*c*) and s. 672.46(2) (transfers to a psychiatric institution or to a hospital). In effect, the appellant urges us to infer from the fact that hospital consent to timing is not required in these situations that it similarly should not be required under s. 672.62. We cannot agree.
17. Section 672.58 is unique in that it requires an accused to be subject to treatment and authorizes medical personnel to administer it without the accused’s consent. The section is not concerned simply with admission but with treatment upon admission. Thus, the provision deals with distinct situations and this argues against drawing any inference from distinct and different provisions about the meaning of this one. Moreover, any potential inference that might otherwise be drawn from the absence of a consent requirement in these other provisions is negated by the language in s. 672.62. It expressly makes the hospital’s consent relate to the disposition order itself, not simply to the treatment to be carried out pursuant to it.
	* 1. The Broader Context
18. The interpretation that we arrive at looking at the text of the provisions in their statutory context is reinforced by other, broader contextual considerations. We will refer to the purpose of the scheme and the artificiality of separating “treatment” from “timing” in this context.
19. We agree with the respondent Attorney General of Ontario that the purposes of this scheme point to a broad understanding of the requirement for hospital consent.
20. An order under s. 672.58 is extraordinary in at least two respects. First, it directs that treatment of an accused be carried out without the accused’s consent. The exceptional nature of this power was noted by the then Justice Minister Kim Campbell when she introduced the legislation in 1991:

At present, there is no power to order a person detained pursuant to a Lieutenant-Governor’s warrant to submit to treatment involuntarily. Apart from emergency, there is no power to treat an accused without obtaining consent. We have concluded that the general rule preventing the involuntary treatment of mentally disordered accused ought to be preserved. However, subject to stringent safeguards, the bill permits a court to order involuntary treatment to make the accused fit to stand trial, thereby avoiding a potentially lengthy period of detention. [Emphasis added.]

(*House of Commons Debates*, vol. 3, 3rd Sess., 34th Parl., October 4, 1991, at pp. 3297-98)

1. The *Code* establishes a number of special protections that highlight the unusual nature of this power. As provided for in s. 672.59, the order may only be made if the court is satisfied on the basis of testimony from a medical practitioner that a specific treatment should be administered for the purpose of making the accused fit to stand trial. That testimony must fulfill the detailed criteria set out in s. 672.59(2), including that the treatment is the least restrictive and least intrusive that could be specified for the purpose and that the risk of harm to the accused is not disproportionate to its anticipated benefit. The accused has important procedural rights including notice, and the right to challenge the application and certain treatments including the performance of psychosurgery or electro-convulsive therapy are not permitted: ss. 672.6 and 672.61.
2. Second, by necessary implication, it authorizes medical personnel to carry out that treatment against the accused’s wishes. This is a remarkable provision, given that informed consent of the patient is generally the *sine qua non* of medical treatment. However, s. 672.62, by requiring consent of the hospital or the person responsible for the accused’s treatment, makes it clear that this provision does not oblige them to carry out the court’s disposition order without their consent. As the Court noted in *Mazzei*, doing so “would constitute interference with the authority and responsibility of hospital authorities to provide medical services to persons in their custody according to *their* view of what is appropriate and effective”: para. 34 (emphasis in original).
3. That understanding serves the purpose of safeguarding the accused; hospital consent is one of the “stringent safeguards” referred to by Minister Campbell and is designed to ensure that the order can be carried out safely, both with regard to the accused, other patients and medical personnel. Parliament also intended to respect the important role of the treatment provider and to acknowledge how intrusive these provisions are, not only in relation to the accused but in relation to the institutions and personnel who are called on to administer treatment against the patient’s will. The provisions recognize the importance of the treatment provider’s clinical judgment, not only as to the particular treatment but as to the location, among those designated by the Minister of Health, at which it is to be carried out.
4. This broad understanding of the scope of the required consent is reinforced by the practical realities of providing involuntary treatment to potentially dangerous individuals. The timing of a treatment order for UST accused must be an element of the hospital’s consent because, from the hospital’s perspective, the time at which treatment is to be provided is inextricably linked to the hospital’s ability to provide treatment safely and effectively. The context of the involuntary treatment of a UST accused involves a number of safety considerations. Special precautions must be made when treating these individuals in order to protect the accused, other patients, staff and the public at large. These measures include all rooms being designed for single occupancy only, double air locking doors, furniture specially designed so it cannot be used as a weapon, specially trained staff, perimeter security, sally ports and specialized automated locking doors. If these facilities are not available at a given time, these safety concerns cannot be adequately met and the treatment cannot be provided safely.
5. The appellant would have us draw a line between “suitability of treatment” — that is, whether a specific UST accused will benefit from the type of treatment recommended to which the hospital must consent — and “timing of treatment” as to which its consent is not required. However, this is an artificial distinction in the real world of involuntary hospital treatment. It ignores the fact that the ability of the hospital to administer the suitable treatment is inextricably linked to whether it has the facilities and personnel available to do so. A treatment is not suitable if it cannot be administered.
6. The artificiality of the distinction between “suitability” and “timing” can be seen by looking at the difference between a hospital that does not have the facilities at all and a hospital that does not have the facilities available “forthwith”. Not all hospitals are equipped to handle the most dangerous offenders; they simply do not have the appropriate facilities. Surely, a hospital can refuse to consent to treat a very dangerous offender if it does not have the appropriate facilities to handle him or her. This would not be considered a question of timing. Similarly, a hospital can acknowledge that a UST accused needs specific treatment, but recognize it does not have the proper facilities to treat him or her immediately. In both these cases, the hospital would be unable to provide safe treatment and therefore would be entitled to withhold consent under s. 672.62(1) because the hospital is not suited to safely treat the UST accused at that time. Timing is therefore an essential element of suitability and not distinct from it. Consent under s. 672.62(1) of the *Code* must therefore include timing.
7. Interpreting consent to exclude the element of timing, as the appellant would have us do, leaves allocation of scarce medical and hospital resources to those needing treatment squarely in the hands of the courts. This undermines the ability of hospitals to make medical triage decisions, which could not have been the intent of Parliament in enacting s. 672.62(1) of the *Code*. In making a “forthwith” treatment order, judges are necessarily deciding who will *not* get treatment forthwith just as they are deciding who will. Judges would be deciding who should get medical treatment first, but without any overall sense of the needs and priorities of others who their “forthwith” orders are displacing. Judges would, in effect, be making medical triage decisions but without the benefit of being informed about the other patients awaiting attention.
8. This scheme requires a co-operative and mutually respectful approach if it is to function, and we encourage that approach. However, our colleague’s suggestion at paras. 118 and 122 of her reasons that judges should routinely inquire into matters of bed availability or the hospital’s ability to safely carry out treatment immediately cannot have been Parliament’s intent in enacting the hospital consent provision. It does not strike us as likely that this scheme intended that the scarce resources of both the courts and the health care system should be devoted to judges micromanaging medical triage decisions and health care providers defending their triage decisions in court. Moreover, a judge’s decision to overrule the hospital on these matters may well affect the important rights and interests of other people needing treatment. Quite apart from the impracticality of seeing the judge’s role in this way, it also undermines rather than furthers the broader objectives of protecting the rights of the accused as well as those of others needing treatment and the broader public. We do not think, with respect, that these are matters that Parliament intended should routinely be decided by judges making disposition orders under s. 672.58 of the *Criminal Code*.
	* 1. Conclusion
9. We conclude that the text, context and purpose of the provisions show that the hospital’s consent is required in relation to all the aspects of the disposition order made under s. 672.58 and, absent that consent, the court may not make the order. This conclusion is subject only to what we will say in the next section of our reasons in relation to circumstances in which a judge is convinced that the hospital’s refusal of consent breaches the accused’s *Charter* rights and that an order for immediate treatment is an appropriate and just remedy for that breach.
	1. The Consent Requirement and Section 7 of the Charter
10. We agree with the Court of Appeal that the consent requirement does not deprive the accused of procedural fairness and that it is not unconstitutionally vague or arbitrary. To the extent that it has any potential to infringe the accused’s s. 7 rights, we agree with the respondent CAMH that any potential violation of s. 7 rights results from the exercise of the hospital’s discretion to withhold consent conferred in s. 672.62(1) in a particular case, and is not inherent in the section itself.
11. No such breach was established. As the Court of Appeal pointed out, there is no evidence that a six-day delay in starting treatment might impair the likelihood of the appellant becoming fit to stand trial within the 60-day statutory window provided in s. 672.59(2), and there is no suggestion that the six-day delay in any other respect infringed the appellant’s right to life, liberty or security of the person. There is, accordingly, no basis on which to find that the hospital’s exercise of discretion not to consent to immediate admission for treatment had any unconstitutional effects on the appellant.
12. That said, although we think it would be exceedingly rare, we would not rule out this possibility in other cases. A judge proposing to make a disposition is entitled to consider, in an appropriate case, whether a refusal of consent will have the effect of unconstitutionally limiting the accused’s rights to life, liberty or security of the person in a fashion that does not accord with the principles of fundamental justice. If so persuaded, the judge would also be entitled to consider whether ordering an immediate admission would constitute an appropriate and just remedy for that breach. While we think the circumstances under which this inquiry is appropriate will be rare, the *Charter* assures that judges and not the person in charge of the hospital where the accused is to be treated will have the last word in terms of the disposition order where the accused’s *Charter* rights would otherwise be compromised. That, however, is not this case.
13. Disposition
14. We would dismiss the appeal without costs.

 The reasons of McLachlin C.J. and Moldaver, Karakatsanis and Wagner JJ. were delivered by

 Karakatsanis J. —

1. Overview
2. When an accused person is found unfit to stand trial under Part XX.1 of the *Criminal Code*, R.S.C. 1985, c. C-46, the court may order involuntary treatment to render that person fit for trial, provided that the hospital administering the treatment consents. Often, the hospital withholds its consent until mental health beds become available. Consequently, treatment cannot always start immediately.
3. As a result, the unfit accused waits in line ― typically in jail ― for a bed to become free, and both treatment and the trial are delayed. Bed shortages in mental health hospitals thus create an ongoing tension between medical resource constraints and the accused’s medical, legal and liberty interests.
4. In this case, the accused was found unfit to stand trial. The hospital indicated that it would not have a bed available for six days, but the hearing judge nonetheless issued a treatment order directing that the accused be taken to hospital “forthwith”. The hospital appealed, and the Court of Appeal concluded that since the hospital had not consented to the start date of the order, the judge did not have the jurisdiction to issue the treatment order. Further, the Court of Appeal found that the consent provisions did not violate the *Canadian Charter of Rights and Freedoms*.
5. The issue in this case is whether it is the court or the hospital that has the final say about when treatment shall commence when faced with bed shortages. Can a valid treatment order issue, absent hospital consent as to the timing of the order? The answer depends on the scope of hospital consent required before a treatment order can be made under Part XX.1 of the *Code*.
6. The respondents, the Centre for Addiction and Mental Health (CAMH), the Mental Health Centre Penetanguishene (MHCP), and the Attorney General of Ontario, say that the hospital’s right to consent means that it must agree to all the terms and conditions of the treatment order before it can be issued. When there arebed shortages, hospitals have the right to determine when treatment will commence. Orders for treatment to start “forthwith” can result in overcrowding, compromising the safety of patients and staff, and the priority of other patients. Hospitals are in the best position to triage patients, and they can withhold consent on that basis.
7. The appellant, Mr. Conception, says that the judge must have the final say as to when treatment will commence. The hospital would only be able to assess the medical interests of the accused, in relation to other (waiting) patients, whereas the judge is able to consider all the interests at stake, including the alternative detention or release arrangements for the accused.
8. For the reasons that follow, I conclude that the hospital’s consent is not required to all the terms and conditions of the treatment order. When the consent requirement is read in its proper statutory context, it is clear that hospital consent is required for the specified treatment. The hospital must be willing, on medical grounds, to administer the particular treatment.
9. Bed shortages and patient wait lists ― the need to manage general resource pressures ― do not permit a hospital to refuse, or defer, consent. It is the judge who will consider bed availability, along with the accused’s liberty and security interests and the need for procedural fairness, in determining the timing of the treatment order. The hospital can advise the judge of any concerns about its ability to safely carry out the treatment on the date specified by the judge, even if it were to give the accused priority. Should the hospital consider the timing unreasonable, it may appeal the judge’s decision and the treatment order will be automatically stayed.
10. I agree with the Court of Appeal that the order in this case should not have been issued. However, while the Court of Appeal reasoned that consent is an “umbrella” term, requiring agreement with all aspects of the treatment order, including timing, I conclude that consent is focussed only on the specified treatment. Because of my conclusions on the meaning of “consent”, I need not consider the parties’ arguments regarding the *Charter*.
11. History of the Proceedings
12. Mr. Conception was arrested on a charge of sexual assault after grabbing the breast of a staff member at the CAMH while receiving treatment there. He appeared in court on April 13, 2010, the day after his arrest, and Hogan J. found him unfit to stand trial. Following the testimony of the CAMH forensic psychiatrist and the recommendation of Crown counsel, the judge decided to issue a treatment order.
13. Crown counsel raised the issues of bed availability and safety. The psychiatrist testified that treatment would be more appropriate at MHCP because the accused’s charge related to a staff member at CAMH. Crown counsel then relayed the information, received from CAMH’s bed coordinator, that a bed would be available at MHCP within six days.[[1]](#footnote-1)
14. The judge asked why she should leave it to hospital administrators to determine priority. Crown counsel submitted that the result of ordering that the accused receive a bed today would be to displace someone else on the waiting list. Not persuaded, the judge noted:

. . . I make orders that people against . . . their will have drugs administered to them. That is extraordinarily serious and we do that because we feel it is absolutely necessary and that means now, not a week from now and I understand that, as I said, and I do not do it lightly when I do things like this, but I understand it does create disruption. But, you know, it would probably be better if he is in a bed in the hall of a psychiatric hospital than if he is in the medical unit [of a jail] not getting what I have been told is absolutely necessary treatment for, you know, a week. [A.R., vol. I, at pp. 8-9]

1. The judge issued a treatment order which directed that Mr. Conception “be taken directly from court to the designated hospital and from hospital directly back to court. Accused is not to be taken to a jail or correctional facility under any circumstances.”[[2]](#footnote-2) Court Services personnel delivered the appellant to MHCP and left him in a hallway.
2. The hospitals, CAMH and MHCP, appealed the treatment order pursuant to s. 672.72 of the *Code*. The order was automatically stayed when the appeal was launched, pursuant to s. 672.75 of the *Code*. The appellant was eventually treated starting April 26, 2010, and his charges were stayed in June 2011.[[3]](#footnote-3) While the validity of the treatment order is now moot, all parties agreed that the underlying issues require resolution.
3. In May 2012, the Ontario Court of Appeal allowed the appeal and set aside the treatment order.[[4]](#footnote-4) The court concluded that the judge did not have the jurisdiction to issue the treatment order without the consent of the hospital and that the hospital had the right to withhold consent to any term and condition including the commencement of the treatment period.
4. The Statutory Regime
	1. Part XX.1 of the Criminal Code
5. Part XX.1 of the *Code* deals with persons in the criminal justice system who are experiencing a mental health disorder. It authorizes courts to order assessments of accused persons who may be unfit to stand trial, or not criminally responsible for an offence, and to make appropriate dispositions in each case. It gives courts or Review Boards oversight of mentally ill accused who have been conditionally released or detained.
	1. Unfit to Stand Trial Regime
6. The cognitive threshold for fitness to stand trial is very low. A person could be ill enough to require civil commitment, but still be considered fit.[[5]](#footnote-5) The treatment order regime in Part XX.1 is intended only to bring mentally ill accused persons to the cognitive threshold required to proceed to trial.
7. The issue of fitness may arise at any stage of the proceedings if the court has reasonable grounds to believe the accused is unfit to stand trial. The court may order an assessment (ss. 672.11 and 672.12) to determine whether the accused is unfit to stand trial; subject to some exceptions, the assessment must be completed within five days (s. 672.14). Subsequent to the assessment, the court may direct a trial of the accused’s fitness (s. 672.23).
8. When an accused is found to be unfit to stand trial, the court may make a treatment order under s. 672.58 to render the accused fit for trial.
	1. Treatment Order Regime
9. A court’s discretion under s. 672.58 to order treatment to render an individual fit for trial is subject to stringent safeguards and timelines.
10. Given the potential for involuntary medical treatment, one such safeguard is the requirement for hospital consent set out in s. 672.62(1)(*a*). Relevant provisions are as follows:

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

. . .

**672.62** (1) [Consent of hospital required for treatment] No court shall make a disposition under section 672.58 without the consent of

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

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

(2) [Consent of accused not required for treatment] The court may direct that treatment of an accused be carried out pursuant to a disposition made under section 672.58 without the consent of the accused or a person who, according to the laws of the province where the disposition is made, is authorized to consent for the accused.

**672.63** [Effective date of disposition] A disposition shall come into force on the day on which it is made or on any later day that the court or Review Board specifies in it, and shall remain in force until the Review Board holds a hearing to review the disposition and makes another disposition.

1. Pursuant to s. 672.1, both the person in charge of the affected hospital and the accused are “party” to s. 672.58 treatment orders, and may therefore appeal against a treatment order to the Court of Appeal (ss. 672.1 and 672.72). Filing of such an appeal automatically suspends the application of the order pending the determination of the appeal (s. 672.75).
2. The Broader Factual Context
	1. The 102 Court-CAMH System
3. The 102 Court is a specialized Mental Health Court in Toronto. It applies the provisions of Part XX.1 of the *Criminal Code* to mentally disordered accused persons.
4. Most unfit accused suffer from a psychotic illness. The treatment required to make an individual fit to stand trial is generally antipsychotic medications provided in a safe context.[[6]](#footnote-6)
5. Toronto’s CAMH works cooperatively with 102 Court to admit and treat accused persons subject to treatment orders. A psychiatrist from CAMH attends 102 Court five afternoons per week to conduct on-site assessments of mentally ill accused persons’ fitness to stand trial. A provincial forensic bed registry tracks the availability of beds and is available to Crown counsel and the hospitals. CAMH’s Court Liaison is usually present in 102 Court to assist with locating bed placements and predicting wait times,[[7]](#footnote-7) and has the delegated authority to give the hospital’s consent to the treatment order, typically by stating the estimated day that the hospital will be able to admit the person.[[8]](#footnote-8)
6. Concerned about mentally ill accused waiting in jail until a treatment bed became available, some 102 Court judges began issuing “forthwith” orders, ordering that the accused be sent to hospital immediately without a stop-over in jail.[[9]](#footnote-9)
7. Despite substantial increases in the number of forensic beds and reductions in wait times, bed shortages mean that the hospitals are not always able to accommodate the needs of the criminal justice system on the timelines expected by the courts.
	1. Current Consent Protocols
8. CAMH’s Statement of Principles and Practices for Admission Prioritization was introduced in October 2010, several months after Mr. Conception’s treatment order was issued.[[10]](#footnote-10) It applies to all admissions and is a response to the constraints of waitlists and frequent over-capacity of inpatient units.
9. The first Principle is “[n]o one waits who cannot”.[[11]](#footnote-11) This is explained: “If the accused is acutely mentally unwell and requires immediate hospitalisation, or if the accused is subject to Court orders or Dispositions of the [Ontario Review Board] which do not permit other placements, admission is arranged expeditiously” (emphasis added).[[12]](#footnote-12) Under Principle 2, “less seriously unwell persons” are generally admitted according to the date of the order or request, “while allowing flexibility for clinical need”.[[13]](#footnote-13)
10. With respect to Principle 4, the Statement says: “It will be presumed by the court that [the hospitals] will consent to treat (s.672.62) all accused who have been found ‘unfit to stand trial’” where the criteria specified in the *Code* (under s. 672.59) are met. Dr. Simpson, the Person in Charge of CAMH, testified that this presumption of consent is qualified, subject to bed availability.[[14]](#footnote-14)
11. However, Dr. Simpson also emphasized that “clinical emergency trumps all other things”[[15]](#footnote-15) and “[n]o one waits who cannot”.[[16]](#footnote-16) If there is no bed available for a clinical emergency, CAMH may use one of its seclusion rooms, provided doing so does not endanger other patients.[[17]](#footnote-17)
	1. Consequences of Delay: Waiting in Jail
12. In the 102 Court-CAMH system, where a forensic bed is unavailable or is being held for another patient, unfit accused persons awaiting treatment are usually remanded to wait in jail.[[18]](#footnote-18)
13. Mentally disordered patients do not typically fare well as inmates. They are frequently victims of intimidation and violence and are more likely than the general prison population to attempt suicide, self-harm, or self-destructive behaviour. An experienced correctional officer testified in this case that the mental health care needs of mentally ill accused persons in provincial jail are frequently neglected due to lack of special units and trained personnel.[[19]](#footnote-19) Fewer than one-third of Ontario provincial jails have special units for inmates with mental illness or developmental disability.[[20]](#footnote-20) Where there is no special unit, or where the unit is full, mentally ill accused persons are typically held in segregation cells.[[21]](#footnote-21)
14. Analysis
	1. Overview
15. No court shall make a treatment order without the consent of the treating hospital: s. 672.62(1). The dispute in this case centers on the scope of that consent requirement. In particular, which aspects of a treatment order require hospital consent? Can a valid treatment order be issued absent hospital agreement to the specified start date?
16. The respondent hospitals, as well as the Attorneys General, say that the hospital’s consent is required for all aspects of the treatment order. For the order to be valid, the hospital must agree not only to perform the treatment, but also to the timing and any other conditions of the “disposition”. A treatment order cannot issue without the hospital’s agreement to all aspects of the order.
17. The appellant says that the hospital’s consent need only extend to its willingness to administer the specified treatment. The hospital cannot use the consent requirement to control the timing or other conditions of treatment, particularly based on bed shortages and waiting lists.
18. In my view, the hospital’s consent is required only to the treatment itself, and cannot be withheld on the basis of efficient management of hospital resources. The hospital consent requirement must be read in the context of Part XX.1 of the *Criminal Code*. A contextual reading makes clear that the consent provisions do not permit the hospitals to make decisions about the timing of the treatment (and by extension, the timing of the trial and the interim detention conditions of the accused) based on the medical priority of an accused against other patients on the waiting list for a bed. In setting the start date for treatment, the judge will consider bed shortages, but she does so along with the liberty, security and procedural fairness interests of the accused, as well as assessing the impact of waiting in jail and the delays to the trial.
19. Before a judge can make a treatment order, the consent provision under s. 672.62(1) requires that a hospital indicate it is willing to administer the treatment. The hospital may only refuse consent if it objects to the specified treatment on medical grounds. In exceptional circumstances, the lack of a bed, or other alternative, may mean that the hospital is not able to safely carry out the treatment ― even if the hospital gives the accused priority for the date chosen by the judge. In such cases, if the hospital believes that the judge has acted unreasonably in setting the date, it can appeal and the decision can be reviewed.
20. I will first explain why, in my view, the scope of the consent requirement is limited to the treatment itself, and consent is not required to the associated timing and conditions. I will then discuss how bed shortages are relevant to the treatment order. Finally, I will outline an efficient process for dealing with concerns about the timing of the treatment order.
	1. The Scope of Consent
21. The respondents say that because s. 672.62(1) directs that “[n]o court shall make a disposition under section 672.58 without the consent of (*a*) the person in charge of the hospital where the accused is to be treated”, and because the “disposition” under s. 672.58 permits an order directing that “treatment of the accused be carried out for a specified period not exceeding sixty days, subject to such conditions as the court considers appropriate”, hospital agreement to all aspects of the treatment order is required. The hospital must agree not only to perform the treatment, but also to the timing, duration, and any other conditions of the “disposition”.
22. The appellant says that the treatment order provisions separate the medical appropriateness of the treatment from its timing. Consent is required only with respect to the treatment. While s. 672.58 refers to the court making an order directing that “treatment . . . be carried out for a specified period” (this is the “disposition”), s. 672.63 separately directs that “[a] disposition shall come into force on the day on which it is made or on any later day that the court or Review Board specifies in it”. Thus, the disposition itself ― which requires hospital consent, according to s. 672.62(1)(*a*) ― may be separate from the date that it comes into force, or commences, which s. 672.63 authorizes the court to specify.
23. There is no doubt that s. 672.62(1) makes hospital consent a prerequisite to any treatment disposition. However, the issue remains: to what does the consent relate? Is consent required to all terms and conditions of the “disposition”? Or is consent merely required to the specified treatment?
24. I do not find the respondents’ submissions on the language of s. 672.62 determinative. Section 672.62(1) does not provide that the consent is required for all aspects of the disposition; rather, it says that the disposition under s. 672.58 cannot be made without the consent of the hospital or person treating the accused. Further, the judge may fix the timing of the disposition pursuant to s. 672.63. The disposition under s. 672.58 is an order directing the treatment of the accused for a specified period (a maximum duration of 60 days), together with any conditions the judge considers appropriate. Obviously, if consent to the treatment is not provided, there can be no disposition ordering such treatment.
25. In my view, the language of these provisions, read in isolation, does not provide a clear answer to the scope of a hospital’s discretion to withhold consent. However, the modern rule of statutory interpretation requires that “the words of an Act are to be read in their entire context and in their grammatical and ordinary sense harmoniously with the scheme of the Act, the object of the Act, and the intention of Parliament”: E. A. Driedger, *Construction of Statutes* (2nd ed. 1983), at p. 87. Here, interpreting the provisions in light of (1) the purposes of Part XX.1, the treatment order regime and the consent requirement, (2) the scheme of strict judicial control and oversight with strict timelines, and (3) the appeal and automatic stay provisions, leads to the conclusion that the requirement for hospital consent relates only to a hospital’s willingness to deliver a particular treatment. It does not provide the hospital with a veto over the terms and conditions of the treatment order, nor one that can be exercised for any reason.
	* 1. Legislative Purpose
			1. Purpose of the Part XX.1 Regime; Protecting the Interests at Stake
26. This Court identified the purposes of Part XX.1 in *Mazzei v. British Columbia* *(Director of Adult Forensic Psychiatric Services)*, 2006 SCC 7, [2006] 1 S.C.R. 326:

. . . the new legislative scheme retains the former’s overall purpose and its emphasis on the medical treatment of the NCR [not criminally responsible] accused as merely an effect or an incident of Parliament’s primary objective of protecting the public and managing an accused’s safety risk, pursuant to its criminal law power. The new element added in Part XX.1 is an assurance of procedural fairness and dignity for the NCR accused, and a commitment to ensure that the NCR accused’s liberty interests are to be infringed as minimally as possible. [Emphasis added; para. 27.]

1. Consideration of the significant *Charter*-protected s. 7 liberty interests at stake in the regime is “built into the [Part XX.1] statutory framework” at “every step of the process”: *Penetanguishene Mental Health Centre v. Ontario (Attorney General)*, 2004 SCC 20, [2004] 1 S.C.R. 498, at para. 53. See also *Winko v. British Columbia (Forensic Psychiatric Institute)*, [1999] 2 S.C.R. 625, at paras. 16 and 42.
2. When the Bill enacting Part XX.1 was under discussion in the House of Commons, the Minister of Justice, Kim Campbell, in describing the treatment order power, stated that “subject to stringent safeguards, the bill permits a court to order involuntary treatment to make the accused fit to stand trial, thereby avoiding a potentially lengthy period of detention”.[[22]](#footnote-22)
3. Treatment orders serve at least two purposes. First, they seek to render the accused fit to stand trial, in order to protect the rights to a timely trial and procedural fairness, as well as to safeguard the public interest in accused persons standing trial. Second, they serve to ensure that the accused’s liberty is minimally impaired. While the medical and legal interests of accused persons are both at stake, the ultimate purpose of treatment orders is to protect the legal interests of the accused.
4. The timing of a treatment order directly impacts the timing of the trial. And since the alternative to a treatment order is usually detention in a jail that is ill-equipped to accommodate the mental health issues of unfit individuals, the timing of the order also affects the interim detention conditions of the accused. The timing therefore also affects the dignity, security and liberty interests of the accused ― interests that Part XX.1 seeks to protect.
5. The interpretation of the consent requirement advanced by the respondents, which gives the hospital control over timing and other conditions, is difficult to reconcile with the purposes of the regime. Requiring consent to all terms of a treatment “disposition” would effectively give the hospitals a broad veto over whether a treatment order could be issued, and control over the timing ofthe treatment, without regard to the accused’s legal interests.
6. Nothing in the *Code*, or any other legislation, requires hospitals to consider the detention conditions of unfit accused that are not in their charge when making admission decisions, and they are not in a position to properly do so. Nor are designated hospitals under any legal duty to provide procedural protections to the accused when determining the timing of a treatment order. The triage process conducted by the hospital is only a determination of priority between the medical interests of the accused and other patients ― it does not account for the liberty or other legal and *Charter* interests of the accused.
7. Therefore, it would not be consistent with the purposes of Part XX.1 for hospitals to control the timing and conditions of a treatment order. Hospitals must continually manage for the most effective use of their resources and patient intake protocols. It is for a judge to weigh the accused’s liberty, security and legal interests against the hospital’s challenges in giving priority to the accused. As I discuss later, the judge will consider any bed shortages in setting the start date of any treatment. The purposes of Part XX.1 support a more limited scope for the consent provision, focused on the hospital’s willingness to administer the specified treatment.
	* + 1. Purpose of the Consent Provision
8. Part XX.1 empowers judges to make various orders[[23]](#footnote-23) requiring hospitals to admit accused persons, without the hospital’s consent, even though they may also cause administrative difficulties in immediately accommodating mentally ill accused persons. Thus, the scheme of the *Code* does not generally require hospital consent simply because the treatment order makes demands on hospital resources.
9. Consent is required only under the treatment order regime. This is no coincidence, given that the treatment order provision is also the only provision in Part XX.1 that permits a court to order medical treatment without the consent of the accused.
10. The reason hospital consent is required is to protect the accused’s medical interests and to respect the hospital’s professional right not to be forced to administer medical treatment. It is one of the “stringent safeguards” on court-ordered involuntary treatment of a vulnerable accused.
11. Limiting the power to withhold consent to concerns about the medical appropriateness of the treatment itself respects the professional judgment of the hospital as to whether it should administer the particular treatment. It also acts as a safeguard to ensure that the medical interests of the accused are not compromised by a treatment to which he does not consent. At the same time, it permits the judge to protect the legal interests of the vulnerable accused when setting the timing of the order. This interpretation safeguards procedural protections, judicial supervision of the detention, and the purposes of Part XX.1.
12. Thus, the consent requirement, examined purposively in its legislative context, is limited to whether the hospital would be willing to carry out the specified treatment. It serves to ensure the expert administration of medically appropriate treatment, rather than to accommodate the hospital’s resource constraints.
	* 1. Scheme of the Treatment Order Regime
13. Through Part XX.1, Parliament sought to ensure procedural fairness, and minimally infringe the liberty interests of the accused, by setting detailed time limits and providing for judicial (or Review Board) control and oversight of all aspects of the regime.
14. Pursuant to these controls, a treatment order has maximum duration of 60 days (ss. 672.58 and 672.59); several pre-conditions must be met before the order can be granted, based upon the evidence and opinion of a medical practitioner who has assessed the accused (s. 672.59); the accused has the right to challenge the application (s. 672.6); certain treatments cannot be prescribed under the order (s. 672.61); consent to the order is required from the treating hospital or doctor, but not from the accused (s. 672.62); and the court can specify the effective date of the order (s. 672.63).
15. If hospitals may refuse consent, or dictate the timing of a treatment order, for any reason, including its internal operations and wait lists, it would be a significant derogation from Part XX.1’s comprehensive scheme of judicial controls and tight timelines.
	* 1. Appeal and Stay Provisions
16. A limited scope of the consent requirement also gives effect to the appeal (s. 672.72) and the stay provisions (s. 672.75) in the treatment order regime. Section 672.75 provides for an automatic stay upon appeal by any party.
17. The automatic stay of a treatment order upon appeal by the institution would be meaningless if the treatment order could not be issued absent hospital consent to all its terms and conditions. If a hospital could simply withhold consent when it objected to terms, there would never be any need for it to appeal. Rather, the scheme provides a stay and contemplates a hospital appeal precisely because certain “conditions” of the treatment order ― including the timing ― are decided by the court. An appellate court would be in a position to review the judge’s decision based upon the information before the court.
18. Conversely, a delay caused by the hospital withholding consent to a future date cannot easily be challenged. Although an accused can appeal against the treatment order under s. 672.72(1), this is an onerous challenge for an unfit accused and the appeal is unlikely to be heard before the commencement date of the order. Moreover, because the order usually issues when the treatment is involuntary, the accused is unlikely to seek its earlier implementation.
19. In any event, the hospital’s decision would not easily be susceptible to appellate review. If consent can simply be withheld by the hospital, there may well be little information before the court other than a refusal to consent to an earlier date.
20. My colleagues contend that “[i]f . . . consent to a ‘disposition’ as required by s. 672.62 does not require consent as to timing of treatment, it must follow that an appeal under s. 672.72 from a ‘disposition’ cannot relate to the timing of the treatment either” (para. 25). To be clear, my conclusion is not that the timing of the treatment order is not part of the *disposition*. Rather, I conclude that the timing of the order does not fall within the hospital *consent requirement*. Nothing prevents the hospital from appealing the disposition made by the judge ― respecting its timing or any other aspect ― if it believes the judge’s decision was unreasonable.
21. Thus, the appeal and stay provisions are consistent with a more limited consent requirement under Part XX.1: consent relates only to the hospitals’ willingness to deliver the particular treatment.
	1. The Role of Bed Shortages
22. The respondent hospitals argue that bed shortages directly affect their ability to carry out treatment. However, designated hospitals under Part XX.1 take on a forensic role and are presumptively equipped to treat unfit accused persons.
23. Usually, the management of bed shortages is more closely tied to the efficient management of hospital resources. The CAMH Statement of Principles and Practices for Admission Prioritization suggests that, barring medical emergency, priority is granted on a first come, first served basis. No doubt it is simpler to forecast bed availability in light of the existing waiting list, subject only to medical emergencies. But in the context of Part XX.1, medical emergencies are not the only measure of urgency or priority.
24. Even where an unfit accused’s treatment is not “medically urgent” according to hospital criteria, denial of immediate treatment may nevertheless put his physical safety and life in jeopardy for reasons that are wholly unknown to the hospital and that are impossible for the hospital to assess. Only judges will be able to assess the risks that would flow from failing to immediately treat an unfit accused because many of the greatest dangers will result not from the “medical urgency” of this treatment as seen by hospitals, but rather from the risks that such an accused would face in jail. Medical triage and hospital priority protocols do not account for the legal interests of the unfit accused.
25. There may also be exceptional circumstances where the lack of a bed means that the hospital cannot safely administer the treatment, despite treating the accused as a priority. Doctors should not be ordered to provide treatment in circumstances that are unsafe to patients or staff.
26. However, the record suggests such situations will be rare. Hospitals find the means to deal with medical emergencies, under the principle that “[n]o one waits who cannot”.[[24]](#footnote-24) Dr. Simpson testified that when the hospital deems it truly necessary, it finds room.[[25]](#footnote-25) When a judge makes a treatment order, the hospital must take it to indicate that treatment is necessary as of that date.
27. This may mean that the hospital will have to move a less critical patient to a different ward, use emergency seclusion areas or otherwise accommodate the accused, much as it would in order to accommodate a medical emergency. Under Part XX.1 of the *Code*, the designated hospitals may have to accommodate the exigencies of the criminal justice system.
28. Sometimes bed shortages will affect the ability of a hospital to carry out treatment safely; but this is distinct from whether the treatment is otherwise medically suitable. These are important but separable concepts. Thus, while bed shortages are not a basis for the hospital to refuse consent, they are part of the circumstances in which the judge exercises her discretion in deciding the start date of a treatment order.
29. I would add this. While the state must resource its hospitals so as to accommodate a judge’s order under the *Code*, this does not mean the courts can expect a perfect system, with treatment facilities available immediately in all cases. Nothing in the *Code* requires that hospitals be resourced to ensure there is always an empty bed waiting. If the hospital is concerned about bed unavailability, or its ability to safely carry out the treatment immediately, the discussion about triage can take place before the judge. The judge is in the best position to deal with the various interests, in an informal and co-operative process.
	1. The Treatment Order: A Collaborative Process
30. Despite the tensions created by bed shortages, the dedicated professionals who work daily in the mental health courts work co-operatively in implementing Part XX.1. In this case, for example, this collaborative process resulted in numerous steps ― the assessment, the fitness hearing, and the treatment order hearing ― being dealt with in a single day, the day after Mr. Conception’s arrest.
31. Like all decisions of criminal court judges, the decision to issue a treatment order must be reasonable, having regard to all the circumstances. The psychiatrist will have testified as to the need for treatment. The hospital, as a party to the proceedings, is entitled to indicate its preferred timeline, to avoid disrupting other priority patients. The psychiatrist may give her opinion as to how the accused will fare in prison, and whether his treatment prospects would be adversely affected by a delay.
32. However, the timeline proposed by the hospital may not meet the needs of the criminal justice system. For example, the mental (or physical) health of the accused may be jeopardized by waiting in jail before being transferred to hospital; or the required detention in jail may be disproportionate to the actual charges against the accused. In such cases, the court may make further inquiries of the hospital. The hospital may provide information about the current capacity and waiting list of the hospital and whether, if measures were taken to admit the accused on an urgent basis, it could safely provide treatment.
33. This enquiry is consistent with the judge’s role under Part XX.1 and will not usually require a detailed examination of hospital evidence, which would result in delays to treatment and trial. An informal exchange of information, as is current practice, should suffice. This ensures efficiency and is consistent with the direction under s. 672.5(2) of the *Code*, which states that a hearing to make a disposition under Part XX.1 “may be conducted in as informal a manner as is appropriate in the circumstances”.
34. The judge will aim to craft a realistic treatment order accounting for the hospital’s resource constraints, the interests of the accused and the needs of the criminal process. This is consistent with the judge’s broad power to set the conditions of a disposition under s. 672.58 and to set the effective date of the disposition under s. 672.63.
35. Finally, if the court attaches what the hospital considers to be unreasonable conditions to a treatment order (including for example, where treatment cannot safely be provided), the hospital may, of course, exercise its statutory right of appeal, and benefit from the automatic stay. The Court of Appeal is empowered to overturn a treatment order in such a case.
	1. Conclusions
36. For these reasons, I conclude that before a judge can make a treatment order, the consent provisions under s. 672.62(1) require that a hospital must have indicated it would be willing to administer the specified treatment. When read in their full context, the consent provisions do not permit hospitals to assess the priority of the accused against others on the waiting list ― or to withhold consent on the basis of its bed shortages or waitlists. Consent may be withheld only for medical reasons.
37. Judges are charged under Part XX.1 with ensuring procedural fairness and minimal infringement of the accused’s liberty. The judge can consider bed shortages, in light of the medical and legal interests of the unfit accused. It is the court, and not the hospital, that is tasked with fulfilling the ultimate goal of the treatment regime. That goal is to make the accused fit to stand trial, thereby avoiding a potentially lengthy period of detention.
38. If there are exceptional circumstances at the hospital such that, even if the accused is treated as a patient who “cannot wait”, it would not be safe to admit and treat the accused, then the hospital should bring that to the attention of the judge. If the hospital is concerned about the treatment order, its remedy is to launch an appeal, and receive an automatic stay.
39. The Treatment Order Issued in This Case
40. The validity of Hogan J.’s order is now moot. However, the parties agreed that the appeal should proceed.
41. Obviously, all those involved were acting in good faith. Indeed, in many respects, the 102 Court-CAMH system is a good example of co-operation among the various institutions involved in implementing Part XX.1.
42. The record indicates that the hospital’s refusal to agree to the judge’s desired start date for the treatment order ― a refusal they characterize as a denial of consent ― was based on its own waitlists rather than the treatment of the accused. Staff safety was a concern at CAMH because of the sexual assault allegation, and a bed at MHCP would only be available in six days. The hospital argued that an earlier start date would impact the priority of other patients waiting for an available bed.
43. I do not agree with the Court of Appeal that the trial judge lacked jurisdiction to issue a treatment order in this case. It is obvious from the record that the hospital consented to provide the treatment, subject to bed availability. However, I conclude that the hearing judge’s decision regarding the timing of the treatment order was not reasonable.
44. It is clear that the hearing judge was concerned generally about unfit accused waiting in jail, and the impact of the delay upon their mental health. However, she did not base her decision upon the specific circumstances of this case in issuing a “forthwith” treatment order. There was no discussion of the impact on the offender’s treatment prospects resulting from a delay; the holding conditions in the jail where he would likely be sent to wait; or any possible alternatives to detention while waiting for a bed. And there was no information about whether the hospital could safely administer treatment immediately, if so ordered, or when safe treatment could be provided, if he was given priority. These are relevant factors that could have assisted the judge in the exercise of her discretion to issue a treatment order in this case. Like many others at the time, the judge made the treatment order in good faith, but out of frustration with the mental health system’s inability to immediately accommodate patients under treatment orders.
45. As a result, I agree with the Court of Appeal that the judge erred in issuing a “forthwith” treatment order. I would dismiss the appeal without costs.

**APPENDIX**

Relevant Statutory Provisions

*Criminal Code*, R.S.C. 1985, c. C-46

 **672.1** (1) [Definitions] In this Part,

. . .

“disposition” means an order made by a court or Review Board under section 672.54 or an order made by a court under section 672.58;

. . .

 **672.11** [Assessment order] A court having jurisdiction over an accused in respect of an offence may order an assessment of the mental condition of the accused, if it has reasonable grounds to believe that such evidence is necessary to determine

(*a*) whether the accused is unfit to stand trial;

(*b*) whether the accused was, at the time of the commission of the alleged offence, suffering from a mental disorder so as to be exempt from criminal responsibility by virtue of subsection 16(1);

(*c*) whether the balance of the mind of the accused was disturbed at the time of commission of the alleged offence, where the accused is a female person charged with an offence arising out of the death of her newly-born child;

(*d*) the appropriate disposition to be made, where a verdict of not criminally responsible on account of mental disorder or unfit to stand trial has been rendered in respect of the accused; or

(*e*) whether an order should be made under section 672.851 for a stay of proceedings, where a verdict of unfit to stand trial has been rendered against the accused.

 **672.46** (1) [Status quo pending Review Board hearing] Where the court does not make a disposition in respect of the accused at a disposition hearing, any order for the interim release or detention of the accused or any appearance notice, promise to appear, summons, undertaking or recognizance in respect of the accused that is in force at the time the verdict of not criminally responsible on account of mental disorder or unfit to stand trial is rendered continues in force, subject to its terms, until the Review Board makes a disposition.

 (2) [Variation of order] Notwithstanding subsection (1), a court may, on cause being shown, vacate any order, appearance notice, promise to appear, summons, undertaking or recognizance referred to in that subsection and make any other order for the interim release or detention of the accused that the court considers to be appropriate in the circumstances, including an order directing that the accused be detained in custody in a hospital pending a disposition by the Review Board in respect of the accused.

 **672.54** [Dispositions that may be made] Where a court or Review Board makes a disposition under subsection 672.45(2) or section 672.47 or 672.83, it shall, taking into consideration 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, make one of the following dispositions that is the least onerous and least restrictive to the accused:

 (*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.

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

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

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

(*a*) the accused, at the time of the assessment, was unfit to stand trial;

(*b*) the psychiatric treatment and any other related medical treatment specified by the medical practitioner will likely make the accused fit to stand trial within a period not exceeding sixty days and that without that treatment the accused is likely to remain unfit to stand trial;

(*c*) the risk of harm to the accused from the psychiatric and other related medical treatment specified is not disproportionate to the benefit anticipated to be derived from it; and

(*d*) the psychiatric and other related medical treatment specified is the least restrictive and least intrusive treatment that could, in the circumstances, be specified for the purpose referred to in subsection (1), considering the opinions referred to in paragraphs (*b*) and (*c*).

 **672.6** (1) [Notice required] The court shall not make a disposition under section 672.58 unless the prosecutor notifies the accused, in writing and as soon as practicable, of the application.

 (2) [Challenge by accused] On receiving the notice referred to in subsection (1), the accused may challenge the application and adduce evidence for that purpose.

 **672.61** (1) [Exception] The court shall not direct, and no disposition made under section 672.58 shall include, the performance of psychosurgery or electro-convulsive therapy or any other prohibited treatment that is prescribed.

 (2) [Definitions] In this section,

“electro-convulsive therapy” means a procedure for the treatment of certain mental disorders that induces, by electrical stimulation of the brain, a series of generalized convulsions;

“psychosurgery” means any procedure that by direct or indirect access to the brain removes, destroys or interrupts the continuity of histologically normal brain tissue, or inserts indwelling electrodes for pulsed electrical stimulation for the purpose of altering behaviour or treating psychiatric illness, but does not include neurological procedures used to diagnose or treat intractable physical pain, organic brain conditions, or epilepsy, where any of those conditions is clearly demonstrable.

 **672.62** (1) [Consent of hospital required for treatment] No court shall make a disposition under section 672.58 without the consent of

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

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

 (2) [Consent of accused not required for treatment] The court may direct that treatment of an accused be carried out pursuant to a disposition made under section 672.58 without the consent of the accused or a person who, according to the laws of the province where the disposition is made, is authorized to consent for the accused.

 **672.63** [Effective date of disposition] A disposition shall come into force on the day on which it is made or on any later day that the court or Review Board specifies in it, and shall remain in force until the Review Board holds a hearing to review the disposition and makes another disposition.

 **672.72** (1) [Grounds for appeal] 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.

 (2) [Limitation period for appeal] 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.

 (3) [Appeal to be heard expeditiously] 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.

 **672.75** [Automatic suspension of certain dispositions] The filing of a notice of appeal against a disposition made under paragraph 672.54(*a*) or section 672.58 suspends the application of the disposition pending the determination of the appeal.

 *Appeal dismissed without costs.*

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1. Transcript of proceedings before Hogan J., A.R., vol. I, at p. 6. [↑](#footnote-ref-1)
2. Treatment Order, A.R., vol. I, at p. 2. [↑](#footnote-ref-2)
3. A.R., vol. I, at pp. 59-67. [↑](#footnote-ref-3)
4. 2012 ONCA 342, 111 O.R. (3d) 19, at para. 77. [↑](#footnote-ref-4)
5. Cross-examination of Dr. Klassen, A.R., vol. IV, at p. 43. [↑](#footnote-ref-5)
6. Affidavit of Dr. Simpson, A.R., vol. VI, at p. 130. [↑](#footnote-ref-6)
7. Affidavit of Dr. Simpson, A.R., vol. VI, at pp. 133-34. [↑](#footnote-ref-7)
8. Cross-examination of Dr. Simpson, A.R., vol. VIII, at pp. 30-31. [↑](#footnote-ref-8)
9. See, for example, *R. v. R.R.*, 2006 ONCJ 141 (CanLII); *R. v. Consuelo*, Ont. Ct. J., Toronto, Nos. 10-10001715, 10-10004017, 10-70009469, September 14, 2010 (unreported); *R. v. Procope*, Ont. Ct. J., Toronto, Nos. 10009107, 1200160, October 6, 2010 (unreported); *Centre for Addiction and Mental Health v. Al-Sherewadi*, 2011 ONSC 2272, [2011] O.J. No. 1755 (QL). [↑](#footnote-ref-9)
10. Statement of Principles and Practices for Admission Prioritization, A.R., vol. VII, at pp. 185-87. [↑](#footnote-ref-10)
11. A.R., vol. VII, at p. 185. [↑](#footnote-ref-11)
12. *ibid*. [↑](#footnote-ref-12)
13. *ibid*. [↑](#footnote-ref-13)
14. Cross-examination of Dr. Simpson, A.R., vol. VIII, at p. 64. [↑](#footnote-ref-14)
15. A.R., vol. VIII, at p. 16. [↑](#footnote-ref-15)
16. A.R., vol. VII, at p. 185. [↑](#footnote-ref-16)
17. Cross-examination of Dr. Simpson, A.R., vol. VIII, at pp. 14-17, 41, 46, 56-58, 97 and 118. [↑](#footnote-ref-17)
18. Court of Appeal decision, at para. 35. [↑](#footnote-ref-18)
19. Affidavit of Eduardo Almeida, A.R., vol. II, at p. 2, and House of Commons, *Mental Health and Drug and Alcohol Addiction in the Federal Correctional System: Report of the Standing Committee on Public Safety and National Security*, 3rd Sess., 40th Parl., December 2010. [↑](#footnote-ref-19)
20. Affidavit of Linda Ogilvie, A.R., vol. III, at p. 130; cross-examination of Eduardo Almeida, *ibid.*,atp. 19. [↑](#footnote-ref-20)
21. Affidavit of Eduardo Almeida, A.R., vol. II, at pp. 2-3; cross-examination of Linda Ogilvie, A.R., vol. III, at p. 234. [↑](#footnote-ref-21)
22. *House of Commons Debates*, vol. 3, 3rd Sess., 34th Parl., October 4, 1991, at pp. 3297-98 (emphasis added). [↑](#footnote-ref-22)
23. These include assessment orders under s. 672.13(1); warrants of committal pursuant to s. 672.54(*c*); and various detention orders under ss. 672.29, 672.46(2) and 672.93. [↑](#footnote-ref-23)
24. Statement of Principles and Practices for Admission Prioritization, A.R., vol. VII, at p. 185. [↑](#footnote-ref-24)
25. Cross-examination of Dr. Simpson, A.R., vol. VIII, at pp. 14-17. [↑](#footnote-ref-25)