BRITISH COLUMBIA REVIEW BOARD

IN THE MATTER OF PART XX.1 (Mental Disorder) OF THE CRIMINAL CODE R.S.C. 1985 c. C-46, as amended S.C. 2005 c. 22

REASONS FOR DISPOSITION
IN THE MATTER OF

JARED ALAN SALONEN

HELD AT: Forensic Psychiatric Hospital
Port Coquitlam, BC
May 16, 2017

BEFORE:	**CHAIRPERSON:**	**B. Walter**
	MEMBERS:	**Dr. W. Pankratz, psychiatrist**
		A. Markwart

APPEARANCES:
ACCUSED/PATIENT: Jared Alan Salonen
ACCUSED/PATIENT ADVOCATE: T. Reyes
DIRECTOR AFPS: L. Fredrickson/Dr. M. Hediger
ATTORNEY GENERAL: L. Hillaby

INTRODUCTION AND BACKGROUND

[1] CHAIRPERSON: On May 16, 2017, the British Columbia Review Board convened an annual hearing at the Forensic Psychiatric Hospital (FPH) to review its disposition in the matter of Jared Alan Salonen. Mr. Salonen, the accused in this matter, is now 34 years of age.

[2] We are entitled to accept some, none or all of the evidence before us. While we have considered all of the evidence on record in this case, we only recite that which is necessary to our decision.

[3] Mr. Salonen's personal background, including his psychiatric circumstances, his index offence of second degree murder, which occurred on October 4, 2003, and his June 23, 2004 verdict have all been canvassed over the course of 14 previous hearings.

[4] Mr. Salonen's progress under the jurisdiction of the Review Board and the treatment and supervision of the Adult Forensic Psychiatric Service of British Columbia (AFPS) has been fraught with difficulty. Mr. Salonen has persistently failed to engage therapeutically. He has consistently denied that he suffers from a mental illness. He has demonstrated an unremitting attraction to drugs in recent years, at least marijuana, which has demonstrably decompensated or destabilized his mental state. He has persistently demonstrated his impulsivity and willingness to engage in not just verbal, but physical altercations and assaults. He has been described as lacking insight into his disorder, and into the negative impact of illicit substances on his mental state and functioning. He has minimized his aggression, and has consistently failed to accept personal responsibility for his actions. His progress has been tumultuous and uneven.

[5] Aside from routine aggressive posturing, Mr. Salonen has been charged and in 2011, pled guilty to assault causing bodily harm of a peer. That experience has not appeared to reduce his aggression. Early in 2013, he was engaged in another altercation involving police.

[6] Attempts to place Mr. Salonen on less restrictive wards in FPH have been unsuccessful. When he has greater choice of movement, he is prone to relapsing to using substances which are more accessible on less secure units.

[7] As prospects for Mr. Salonen's reintegration were becoming more remote, the Review Board was, in January of 2012, persuaded to provide him with mandated Board-ordered visit leaves. It became obvious to his treatment providers that his behaviour was simply not ameliorating in an environment of strict custody. Mr. Salonen was provided with visit leaves to his brother's home, but these were short-lived and he was asked to vacate. He found independent accommodation in Victoria and was conditionally discharged in May of 2012. However, within six months he demonstrated difficulties in coping, and in dealing with stressors. He was returned to FPH in December of 2012, having endorsed paranoid symptoms.

[8] In January of 2014, Mr. Salonen was provided with another opportunity for discharge subject to conditions. He moved to Abbotsford without much planning, support, or employment prospects. Within a month and a half, police found Mr. Salonen in a paranoid state. He was delivered to hospital and certified, where he tested positive for THC. Attempts to maintain him at Coast Cottages were unsuccessful and he was once again admitted to FPH, where he has remained to date.

[9] Annual reports provided to the Review Board between May of 2014 and May of 2015, chronicle as many as seven assaultive incidents. A risk assessment provided for the Board at Exhibit 66 provides as follows:

> Mr. Salonen remains a high risk of future violence. He has demonstrated in the index offence that a combination of his personality disorder and drug-induced psychosis have been sufficient to produce a mental state leading him to a (sic) commit a murder. Even when his psychosis appears to have abated, his personality disorder continues to be a driver of violence against co-patients. Mr. Salonen can be a hostile, disagreeable, reactive man who is aggressive and assaultive over trivial irritants or perceived slights or wrongs. There has been no settling of this tendency even with the supervision, support and structure of the hospital. Previous clinicians have commented that it is the hospital context which aggravates these personality disorder features. Unfortunately, Mr. Salonen is now in a place where he will need to find ways to contain the more maladaptive aspects of his personality disorder within the hospital if he wishes to make progress. The alternative, unfortunately, is a continuation of assaultive behaviour and the need for secure containment orf (sic) his risk. The fact that he has resided on Ashworth 1, the most secure unit in the hospital, and is expressing no desire to progress off of it does not bode well for future progress in the near term…

[10] In May of 2015, counsel for the Attorney General sought and obtained an independent assessment of Mr. Salonen, which was tabled as Exhibit 67 at his May 25,

2015 hearing. That assessment, rather than attributing his violence to drug use or psychosis, made it clear that Mr. Salonen's violent tendencies persist whether or not he is psychotic, whether or not he is using substances, and whether or not he is medicated. That assessment concluded that Mr. Salonen's risk is best managed in a hospital setting.

[11] Before his May 2015 hearing, which resulted in a disposition of custody, Mr. Salonen had again engaged in an assault, possibly as a result of the increase in stress that accompanies approaching Review Board proceedings.

[12] Prior to the date of his last hearing in May of 2016, at which time his disposition of custody was extended with his consent, Mr. Salonen had again been charged with assault. He had been violent toward peers despite an absence of psychosis, and despite being treated with depot medication. He was seen as a continuing risk of impulsive violence, and was not interested in therapy. Exhibit 71, a psychology treatment report dated April 8th, 2016, and tabled for his last scheduled hearing, indicates that Mr. Salonen is not considered a good candidate for psychotherapy because he is unwilling to assume responsibility for his behaviour. He either denies his behaviour, or blames others for it. He tends to assume a stance that suggests that he is the victim. He had declined further treatment after six psychotherapy sessions.

EVIDENCE AT HEARING

[13] For the current hearing, Dr. Hediger provided written and oral evidence, in which he reviewed a serious assaultive event in 2016, for which Mr. Salonen has recently been sentenced. Mr. Salonen's historic diagnosis has been one of drug-induced psychosis. However, under Dr. Hediger's care, he has shown overt psychotic symptoms in the absence of, or with only limited substance use. Therefore, Dr. Hediger is now inclined to add a diagnosis of a freestanding psychotic disorder such as schizophrenia, in addition to Mr. Salonen's diagnosis of drug-induced psychotic disorder. Mr. Salonen also carries a diagnosis of antisocial personality traits or disorder.

[14] Mr. Salonen has demonstrated insight into the negative effects of marijuana. He has, over the course of the past year, elected to remain on the secure A1 Unit in order to assist him to abstain. He has, in the main, been successful in this endeavour, although as recently as May 9th, just eight days before this hearing, he did obtain, and admitted to using marijuana even on the most secure unit. Happily, this episode was not accompanied by any relapse to psychosis.

[15] Despite the close monitoring of the A1 unit, there have been ongoing episodes of behavioural conflict, one of which involved a peer trying to slit Mr. Salonen's throat with a broken tile. Despite the turbulence, Dr. Hediger indicates that overall Mr. Salonen is doing well clinically. He has not been persistently or overtly psychotic. He appears settled and presents as fairly cooperative. He has responded to redirection without violence.

[16] According to Dr. Hediger, Mr. Salonen once again appears sufficiently motivated to work toward another opportunity to live in the community. His plan, which Dr. Hediger terms as not unrealistic, would be to progress to the Elm Unit where he would be provided with more mobility and access to grounds and programs, and where he would, incidentally, also have more opportunity to test his resolve to abstain from marijuana. A second aspect of the plan would then be to obtain independent accommodation, perhaps in Abbotsford, and to make a living selling items on Ebay, in addition to his disability income.

[17] Dr. Hediger would prefer to see Mr. Salonen initially discharged to a more supervised setting such as CTC, but he is willing to support Mr. Salonen's plan to exercise visit leaves to the independent apartment he plans to secure. Dr. Hediger is reasonably concerned about Mr. Salonen's chances of success, noting that past attempts at community placement have been unsuccessful once Mr. Salonen has become stressed and overwhelmed by his circumstances.

[18] It is also important that Mr. Salonen maintains, and that his dosages of medications are adequate in order to contain his independent or freestanding psychotic illness and to dampen the emergence of symptoms if he relapses to marijuana use. As he has in the past, Mr. Salonen continues to disagree that he has a freestanding schizophreniform illness separate and apart from his drug-induced psychosis. He continues to prefer the theory that his psychosis is due to drugs and/or is brought on by stress.

[19] Mr. Salonen, in asking for a six-month order of custody, sought to persuade the Board that he is now an adult and takes responsibility for his actions. He says that the index offence was almost 15 years ago, and that he has matured. He clearly wants another attempt at reintegration.

ANALYSIS AND DISPOSITION

[20] The Board’s decision making is governed by s.672.54, and s.672.5401 of the *Criminal Code* (as amended) which provide:

> **672.54** When a court or Review Board makes a disposition under subsection 672.45(2), section 672.47, subsection 672.64(3) or section 672.83 or 672.84, it shall, taking into account the safety of the public, which is the paramount consideration, the mental condition of the accused, the reintegration of the accused into society and the other needs of the accused, make one of the following dispositions that is necessary and appropriate in the circumstances:
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> > **(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;
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> > **(b)** by order, direct that the accused be discharged subject to such conditions as the court or Review Board considers appropriate; or
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> > **(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.
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> **672.5401** For the purposes of section 672.54, a significant threat to the safety of the public means a risk of serious physical or psychological harm to members of the public — including any victim of or witness to the offence, or any person under the age of 18 years — resulting from conduct that is criminal in nature but not necessarily violent.

[21] The Board must first determine whether Mr. Salonen poses a significant threat to public safety as defined in s.672.5401. Although it is considered an expert tribunal in respect of the subject matter within its jurisdiction, the Board is not required or entitled to conduct its own assessment of an accused's significant threat to public safety. As must any adjudicative body, the Board can only evaluate the evidence presented to us at a hearing to determine whether it meets that threshold.

[22] Despite the implementation of s.672.5401, in 2014, the Courts have held that this codification has not changed the interpretation of significant threat, in substance. The jurisdictional threshold test remains that articulated in **Winko v. British Columbia (Forensic Psychiatric Institute)**, [1999] 2 S.C.R. 625:

> [T]he threat posed must be more than speculative in nature; it must be supported by evidence: *D.H. v. British Columbia (Attorney General)*, [1994] B.C.J. No. 2011 (QL) (C.A.), at para 21. The threat must also be "significant"; both in the sense that there must be a real risk of physical or psychological harm occurring to individuals in the community and in the sense that this potential harm must be serious. A miniscule risk of grave harm will not suffice. Similarly, a high risk of trivial harm will not meet the threshold.

> Finally, the conduct or activity creating the harm must be criminal in nature. (Par. 57)

[23] In **Calles v. British Columbia (Adult Forensic Psychiatric Services)**, 2016 BCCA 318, the BC Court of Appeal confirmed that:

> A significant threat to public safety is defined in s. 672.5401 of the *Criminal Code* to mean "a risk of serious physical or psychological harm to members of the public – including any victim of or witness to the offence, or any person under the age of 18 years – resulting from conduct that is criminal in nature but not necessarily violent". The threat posed must be more than speculative and be supported by the evidence. It must be significant "both in the sense that there must be a real risk of physical or psychological harm occurring to individuals in the community and in the sense that this potential harm must be serious. A minuscule risk of grave harm will not suffice", nor will a high risk of trivial harm: Winko, at para. 57. (para. 15)

[24] In summary, a finding of significant threat must be based on evidence rather than speculation. There must be a real risk of physical or psychological harm to individuals in the community that is serious, in the sense of going beyond the merely trivial or annoying. The conduct of concern must be criminal in nature. There must be a foreseeable and substantial risk that the accused would, or is likely to commit a serious criminal offence if discharged absolutely. In making these determinations, we must have regard both to the interests of individual liberty as well as to the paramount consideration of public protection.

[25] Mr. Salonen's diagnosis has now shifted from one of substance induced psychotic disorder, the symptoms of which he experiences when he relapses to substance use, to include a freestanding schizophreniform disorder. This means that Mr. Salonen can experience symptoms of psychosis even when he is otherwise abstinent or using very little marijuana. Despite a previous, lengthy period of time off medication, it now becomes important that Mr. Salonen remains medicated to avoid relapse.

[26] In addition to the ultimately violent index offence, and persistent antisocial and assaultive behaviour in hospital, amounting to what can only be referred to as a significant history of violence; it has become clear that Mr. Salonen can be violent whether or not he is psychotic, and whether or not he has had access to drugs. Mr. Salonen continues to resist accepting that he is mentally ill. He has no access to any network of supportive relationships in the community. Over time, and despite being characterized as insightful into the negative impact of drug use on his mental state and his potential for violence, he has nevertheless, persistently sought and used substances in hospital when the

opportunity presents. He also presents with an extreme interpersonal sensitivity and reacts violently to perceived slights or insults from others. He has repeatedly perpetrated assaults in hospital and has been twice convicted. His exquisite sensitivity to relapse in the face of stressors and becoming overwhelmed has been demonstrated in the course of short-lived discharges and returns to hospital. Between May of 2014 and 2015, he was involved in as many as six impulsive, assaultive incidents. Dr. Hediger described Mr. Salonen's violence as both situationally precipitated but also at times pre-meditated.

[27] We are heartened by Mr. Salonen's motivation to make another attempt to access and to achieve a durable reintegration. Nevertheless, he represents the very definition of a significant threat to public safety and our ongoing jurisdiction over him is amply justified.

[28] Having concluded that Mr. Salonen remains a significant threat, we are required to reconsider and apply the criteria in s.672.54 to the evidence to arrive at the necessary and appropriate disposition in this case.

> The “necessary and appropriate” standard came into force on July 11, 2014. Before then, the Criminal Code required that the disposition be the “least onerous and least restrictive to the accused”. This court has endorsed the Board’s view that the two standards are synonymous – in other words, the “necessary and appropriate” disposition is also the “least onerous and least restrictive” disposition: Ranieri (Re), 2015 ONCA 444 (CanLII), 336 O.A.C. 88, at paras. 20-21. The change in language was meant to clarify the standard and make it easier to understand, not to modify it. Thus, the jurisprudence developed under the least onerous and least restrictive standard continues to apply to dispositions under the necessary and appropriate standard: **McAnuff** (Re), 2016 ONCA 280, par 22.

[29] All parties agreed that the necessary and appropriate disposition in this case is one of custody. The only contest is whether the order should be for 12 months, as suggested by the Director, or of six months, as requested by Mr. Salonen. We do not wish to discourage or demotivate Mr. Salonen from his goals, however, he is currently on the most restrictive ward of this hospital and has not exercised access to the community in at least two years, during which there have been numerous episodes of violence.

[30] At this point, Mr. Salonen needs to be transferred from his secure hospital ward to a less restrictive unit, where he is more mobile and has more access to individuals and at the same time, to temptation in the form of more readily accessible marijuana. That environment will no doubt present a significant challenge to Mr. Salonen's resolve to abstain. His move or transfer to the Elm Unit is unlikely to occur for a period of at least two

months. Once he has demonstrated an ability to abstain and to remain violence free in that environment, he will then be provided with incremental liberties and privileges to the point where he can be assisted to obtain accommodation in the community. His hope for discharge would then have to be preceded by a series of adjustment visit leaves under support and supervision, to assess his ability to function independently. In our view, such a process, culminating in Mr. Salonen's conditional discharge, even if entirely successful, and uninterrupted, is not likely to be achievable in the context of a six-month order. Rather than artificially foreshortening our disposition, and as was explained to Mr. Salonen at the hearing, we have opted to make a 12-month order. We invite the parties, including Mr. Salonen, to approach the Board for an early hearing as plans for his reintegration are implemented and if he reaches the point that conditional discharge becomes both necessary and appropriate during the currency of this order.

Reasons written by B. Walter, in concurrence with Dr. W. Pankratz and A. Markwart