# The Charter, Psychiatry and the Criminal Code

Carla McKAGUE*



* Advocacy Resource Centre for the Handicapped, Toronto, Ontario.

This paper will address the field of psychiatry, the *Charter* and criminal law, and in particular the insanity defence, in light of the Supreme Court of Canada's judgment in the *Swain* appeal,[1] which clarified several central *Charter* issues in this area.

While I do not have expertise in the mainstream of criminal law, nor do I have any personal experience in assisting a client through the initial court process which results in a finding of not guilty by reason of insanity, I do have extensive experience in mental health law. Over the last twelve years I have represented a large number of people who are inmates of psychiatric institutions as a result of a finding of not guilty by reason of insanity or of unfitness to stand trial. I have appeared on their behalf both before the Lieutenant Governor's Board of Review and in other matters concerning their detention and treatment.

I want to preface my remarks on the *Criminal Code* itself by addressing some commonly held beliefs that in my opinion are either incorrect or highly questionable — beliefs that I and many of my colleagues have come to term "psychiatric myths".

## I. PSYCHIATRIC MYTHS

The first psychiatric myth is that people diagnosed as mentally disordered are a small minority of the population, and significantly different from other people. In fact, a 1981 study indicated that one in eight Canadians has spent or will spend time in a psychiatric ward.[2] (Other, more recent, studies suggest the figure may be even larger, perhaps one in five.) These figures cut across socio-economic lines. We are talking about at least one in eight politicians, one in eight truck drivers, one in eight welfare recipients, and one in eight of the people in this room. In other words, psychiatric patients are not "them" — they are *us*, our families and our friends. And in making laws around mental disorder, or subjecting those laws to *Charter* scrutiny, it would be well to remember that.

The second myth is that there is a higher rate of violence among people who have been diagnosed as mentally disordered than among the general public, and therefore mentally disordered offenders present a greater risk to the public than do other offenders. In fact, study

1. See *R.* c. *Swain*, (1991) 63 C.C.D. (3d) 481, reversing *R.* c. *Swain*, (1986) 53 O.R. (2d) 609, 13 O.A.C. 161, 24 C.C.C. (2d) 385, 50 C.R. (3d) 97, 18 C.R.R. 209 (C.A.).

2. Statistics Canada, *One of Eight: Mental Illness in Canada* (Ottawa: Minister of Supply and Services, 1981). See also D. Goldberg and P. Huxley, *Mental Illness in the Community: The Pathway to Psychiatric Care* (London: Tavistock Publications, 1980) for confirmation of similar figures in Britain and the United States.

after study has confirmed that the incidence of violence in this group is no higher than in the general population,[3] and some studies have found it to be substantially lower.[4]

The chief reason for this particular misconception is probably that, when someone who is mentally disordered *is* violent, he or she is likely to be violent in unusual ways and with unusual motives that catch public attention. Not many people, for instance, would easily understand the actions of one of my clients, who is on a Lieutenant Governor's Warrant for attempting to kill his psychiatrist so that he could eat his flesh and be released from the wheel of reincarnation. But the fact remains that the vast majority of people with mental disorders are non-violent, and present no risk to themselves or others.

A third, and related, myth is that psychiatrists can predict with some accuracy what the chances are that a particular individual will engage in violent behaviour. The fact, demonstrated over and over again, is that they cannot. Psychiatrists are no more accurate in making these predictions than are lawyers, homemakers or accountants, and are wrong much more often than they are right.[5] In fact, in the well-known *Tarasoff* case in California,[6] the American Psychiatric Association (APA) submitted an *amicus curiae* brief which includes the following passage:

> *The Court's formulation of the duty to warn fundamentally misconceives the skills of the psychotherapist in its assumption that mental health professionals are in some way more qualified than the general public to predict future violent behavior of their patients. Unfortunately study after study has shown that this fond hope of the capability to predict accurately is simply not fulfilled.*

The brief goes on to cite an APA task force report, which stated:

---

3. F.A. Henn, M. Herjanic & R.H. Vanderpearl, "Forensic psychiatry: Diagnosis & criminal responsibility", 162 J.Nerv.Ment.Dis. 423; H.J. Stedman, J.J. Cocozza and M.E. Melick, "Explaining the increased arrest rate among mental patients: The changing clientele of state hospitals", (1978) 135 Am.J.Psychiat. 816; B.L. Diamond, "The psychiatric prediction of dangerousness", (1974) 123 U.Penn.Law Rev. 439.

4. For example, see J.E. Rappaport and G. Lassen, "Dangerousness: arrest rate comparisons of discharged patients and the general population", (1965) 121 Am.J.Psychiat. 776; L.H. Cohen and H. Freeman, "How dangerous to the community are state hospital patients?", (1945) 9 Conn.State Med.J. 697. See also note 9, *infra*.

5. B. Ennis and I. Litwack, "Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom", (1974) 62 Cal.Law.Rev. 693; J. Monahan, *The Clinical Prediction of Violent Behavior* (Ann Arbor: University of Michigan Press, 1981); S. Pollack, "Principles of forensic psychiatry for psychiatric-legal opinion- making", Chapter 14 in C. H. Wecht, ed., *Legal Medicine Annual 1971* (New York: Appleton-Century-Crofts); A.A. Stone, "Mental health and the law: a system in transition", in *Crime and Delinquency Issues: A Monograph Series* (Rockville: National Institute of Mental Health Center for Studies of Crime and Delinquency, 1975); L. Coleman, *The Reign of Error: Psychiatry, Authority and Law* (Boston: Beacon Press, 1984). See also as examples of judicial pronouncements on this point *In Re Ballay*, 482 F.2d 648 (1973); *People* c. *Burnick*, 14 Cal.3d 306 (S.C.).

6. *Tarasoff* c. *Regents of the University of California*, 17 Cal.3d 750, 518 P.II.2d 342, 11 Cal.Rptr. 910 (1974).

> *Neither psychiatrists nor anyone else have reliably demonstrated an ability to predict future violence or "dangerousness". Neither has any special psychiatric "expertise" in this area been established.*[7]

The brief admitted that in predicting long-term dangerousness, psychiatrists were wrong sixty per cent of the time — worse than chance. More recent studies have shown that they are little, if any, better at predicting short-term dangerousness.[8] The result of this inability to predict is natural; in order to minimize risk, psychiatrists grossly over-predict violence. In perhaps the most striking example I know of, a court decision resulted in the release of 967 residents of a maximum security psychiatric hospital. One-third returned to the community and two-thirds went to ordinary psychiatric hospitals. In the next four and one-half years, only 26 engaged in violent behaviour — a misprediction rate of 97%.[9]

The fourth myth is that psychiatrists can accurately and reliably diagnose mental disorder. Most of the people in this room will have had more than the usual experience of sitting in a courtroom listening to competing psychiatric versions of the truth about a particular individual, and I do not need to dwell on that point. I will indicate that those of my clients with psychiatric histories of five years or more have, on the average, five different and often incompatible diagnoses, and that many studies demonstrate the very low level of validity and reliability of psychiatric diagnosis.[10]

Even more discouraging is that there are studies indicating that not only do psychiatrists disagree on a specific diagnosis, they may also be unable to distinguish between people with and without mental disorder.[11] The most famous exposition of this thesis is a 1973 study by a psychologist named Rosenhan,[12] in which several of his students feigned hearing voices in order to gain admission to psychiatric wards. They all succeeded in being

---

7. American Psychiatric Association Task Force Report 8, *Clinical Aspects of the Violent Individual*, July 1974, 28.

8. C. Webster, B. Dickens and S. Addario, *Constructing Dangerousness: Scientific, Legal and Policy Implications* (Toronto: Centre of Criminology, University of Toronto, 1985).

9. H.J. Steadman, "The Psychiatrist as a Conservative Agent of Social Control", (1972) 20 Social Problems 263; H.J. Steadman, "Follow-up on Baxtrom Patients Returned to Hospitals for the Criminally Insane", (1973) 130 Am.J.Psychiat. 317.

10. M.A. Taylor, P. Gaztanaga and R. Abrams, "Manic-Depressive Illness and Acute Schizophrenia: A Clinical, Family History, and Treatment-Response Study", (1974) 131 Am.J.Psychiat. 678; J. Robitscher, "Isaac Ray Lecture I: Psychiatric Labelling, Predicting, and Stigmatizing" and "Isaac Ray Lecture II: Psychiatric Control of Behavior", (Fall 1977) J. Psychiat. & Law; F.S. Mendelsohn, G. Egri and B.P. Dohrenwend, "Diagnosis of Non-Patients in the General Community", (1978) 135 Am.J.Psychiat. 1163; R.K. Blashfield and J.G. Draguns, "Evaluative Criteria for Psychiatric Classification", (1976) 85 J.Abn.Psychol. 140; F.R. Hine and R.B. Williams, "Dimensional Diagnosis and the Medical Student's Grasp of Psychiatry", (1975) 32 Arch.Gen.Psychiat. 523; Coleman, *op. cit.*, note 5. These are a handful among dozens of such papers; for further references see J. Ziskin, *Coping with Psychiatric and Psychological Testimony*, 3rd ed. (Venice: Law and Psychology Press, 1981).

11. For evidence that it is relatively easy to fake insanity, see D. Pugh, "The Insanity Defense in Operation: A Practicing Psychiatrist Views Durham and Brawner", (1973) Wash.U.Law Quart. 87 and S. Yochelson and S. Saminow, *The Criminal Personality* (New York: Jason Aaronson, 1976).

12. D.L. Rosenhan, "On being Sane in Insane Places", (1973) 179 Science 250.

admitted, and then announced they were no longer hearing voices and behaved perfectly normally. None was discharged as mentally healthy; the discharge diagnosis — an average of 19 days later — was in all but one case "schizophrenic in remission". (The exception was diagnosed manic-depressive.)

More interesting still were the events after the paper was published. Staff of one hospital, stung by the results, claimed that if they had known people would be falsifying symptoms to gain admission, they could and would have recognized them. Rosenhan then announced that in the next few months he would be sending them other "pseudo-patients" seeking admission, and challenged them to identify these people. Out of 193 admissions rated by staff members, forty-one were identified as pseudo-patients by at least one staff member, and a further twenty-three were suspected by at least one staff member. Rosenhan then revealed that he had not sent any pseudo-patients at all.[13]

It is also a myth that psychiatric treatments, particularly the organic therapies such as antipsychotic drugs, are highly efficacious in curing mental disorder. No one would deny that these treatments can be very effective in controlling symptoms of such disorders as schizophrenia and manic depression. However, they are not cures, and they are not even helpful with symptoms in a substantial proportion of patients. Psychiatrists have a rule of thumb known as the "rule of thirds". It holds that one-third of patients will receive substantial benefit from medication, one-third will improve or recover without medication, and one-third will neither improve spontaneously nor benefit appreciably from treatment. When someone is forcibly admitted to a psychiatric hospital and forcibly treated, it is therefore with a roughly one in three chance of significant benefit from the experience. Added to this is the evidence that many people treated forcibly will discontinue medication upon or shortly after release, for reasons which should become apparent when I deal with my next myth.

Another example of the inefficacy of treatment, particularly relevant to the criminal context, was made public in the *Toronto Star* in 1988 in an article titled "Psychopath Treatment a Dismal Flop, Researchers Say".[14] The article reported that a much-touted Ontario treatment program billed during the 1970s as having the potential to cure psychopathy[15] had been a total failure. While it was operating, it had been described by an inter-party federal government committee as "the most promising known for assisting offenders in self reformation." The committee had gone on to recommend that "this technique should be introduced into both maximum and medium security institutions immediately."[16] In retrospect, however, to quote one of the researchers:

---

13. Described in Ziskin, *op. cit.*, note 10, at 350.

14. D. Henton (August 20, 1988).

15. "Psychopathy" is a term roughly equivalent to "sociopathy" or "antisocial personality disorder". In lay terms, it describes a condition which displays none of the generally recognized symptoms of severe disorder such as hallucinations, delusions or paranoid beliefs; it is characterized by what might be described as a lack of conscience, a refusal to recognize that other people have feelings, rights and moral worth, and a solipsistic view that actions are right or wrong only as they benefit or fail to benefit the psychopathic individual himself/herself.

16. *Report to Parliament of the Sub-Committee on the Penitentiary Systems in Canada*. (Ottawa: Ministry of Supply and Services Canada, 1977), at 121-122.

> *We couldn't help but be impressed by how bad the outcome was for that small group of people who were true psychopaths. There's almost no room to do any worse.*[17]

There is also a general, and mythical, belief that organic psychiatric treatments are low-risk. In fact, they are high-risk. Antipsychotic drugs have been shown to produce a condition called "tardive dyskinesia" in about 40% of people taking them for six months or more. This is a generally irreversible degeneration of the central nervous system, usually manifesting itself first by uncontrollable and grotesque facial grimacing.[18] The condition can proceed to affect the entire body so that it is totally disabling. The United States is now facing a rash of damage actions based on tardive dyskinesia; the first two resulted in settlements of approximately $700,000 and $1,000,000.[19]

These drugs have numerous other serious side effects, including several that are life-threatening. For example, a condition called "neuroleptic malignant syndrome" occurs in a totally unpredictable way in people taking antipsychotic drugs; it is not dose-related, and can occur on the first administration of the drug or after years of medication. It kills twenty to thirty per cent of those who contract it, and survivors have a high probability of permanent brain damage, kidney damage or other major impairment.[20] A study by the Coroner's Office of the State of New York found that the leading cause of death in psychiatric hospitals was residents choking to death because antipsychotic drugs had destroyed their gag reflex, allowing food or vomitus easy access to their lungs.[21] These are only a few of the most dramatic effects; a list of all the dangers would be too lengthy for this paper.[22]

Similarly, a committee appointed by the Ontario Ministry of Health to study the use of electro-convulsive treatment ("shock therapy") in Ontario stated in its 1985 report that ECT

---

17. *Supra* note 14.

18. A. E. Lang, "Tardive Dyskinesia", (May 1984) *Modern Medicine of Canada* 549; *Compendium of Pharmaceuticals and Specialties* (published annually by the Canadian Pharmaceutical Association); *Physician's Desk Reference* (published annually by the Medical Economics Co.).

19. *Faigenbaum* c. *Cohen,* No. 79904736 (Wayne Co., Michigan, filed February 14, 1979); *Clites* c. *Iowa,* No. 2-04/2-65599 (Ct. of Appeal, Iowa, filed June 29, 1982).

20. *Compendium of Pharmaceuticals and Specialties (supra* note 18); Physician's Desk Reference (*supra* note 18); M. Rampertaap, "Neuroleptic Malignant Syndrome", (1986) 79 South.Med.J. 331; H. G. Pope, Jr., P. E. Keek, Jr. and S. L. McElroy, "Frequency and Presentation of Neuroleptic Malignant Syndrome in a large Psychiatric Hospital", (Oct. 1986) 143 Am.J.Psychiat. 1227; G. Addonizio, V.L. Susman and S.D. Roth, "Symptoms of Neuroleptic Malignant Syndrome in 82 Consecutive In-Patients", (Dec. 1986) 143 Am.J.Psychiat. 1587; D. Sternberg, "Neuroleptic Malignant Syndrome: The Pendulum Swings", (Oct. 1986) 143 Am.J.Psychiat. 1273.

21. F. T. Zugibe, "Sudden Death Related to the Use of Psychotropic Drugs", in C. H. Wecht, ed., *Legal Medicine 1980* (Philadelphia: W.B. Saunders, 1981).

22. *Compendium of Pharmaceuticals and Specialties (supra* note 18); *Physician's Desk Reference (supra* note 18); P. R. Breggin, *Psychiatric Drugs: Hazards to the Brain* (New York: Springer, 1983); *Rogers* c. *Commissioner of the Department of Mental Health,* 458 N.E. 2d 308 (1983); *In Re guardianship of Richard Roe,* 421 N.E. 2d 40 (1981); *Washington* c. *Harper,* 58 L.W. 42249 (U.S.S.C. 1990).

is responsible for long-term memory loss, and that it is simply not known whether ECT causes brain damage.[23]

I could go on through additional myths, but I will content myself with just one more — the myth that when someone is admitted to a psychiatric institution, his or her legal rights are respected. Those of us working with people who have been hospitalized are fully aware that this is not the case. The most recent documentation to come to my attention is a report of the Office of the Official Guardian in Ontario, which since 1988 has had the responsibility of making treatment decisions on behalf of psychiatric patients who are incompetent to make those decisions and have no other person legally authorized to make those decisions for them.[24] That office has concluded that the law respecting psychiatric treatment of this group of people is being routinely ignored across the province, and that large numbers of people are being treated in defiance of the law, which requires a substituted consent. It reports that many mental health professionals are ignorant of the law, and that:

> *the poor medical attendance at the Provincial psychiatric hospital information sessions leads the Official Guardian to believe that there is little interest in this area*.[25]

23. *Report of the Electro-Convulsive Therapy Review Committee* (Ontario: Ministry of Health, December 1985), at 22. For a considerably more pessimistic view, see P. R. Breggin, *Electroshock: Its Brain-Disabling Effects* (New York: Springer, 1979).

24. I. Mappa, "The Official Guardian's Experience as Substitute Decision Maker: Is it Working?" (1990) [unpublished].

25. *Ibid.* at 19.

It concludes:

> [The Official Guardian] *is extremely concerned about the apparent lack of compliance with the legislation in regard to substitute consent when patients have no family to act on their behalf. The use of Mental Health Act restraint provisions to justify treatment without the informed consent of the Official Guardian when there are no other substitute decision makers available or willing to act cannot be tolerated much longer.*[26]

Or consider a 1973 study examining documents filled out on people admitted to an Ontario psychiatric hospital against their will.[27] One requirement for such an admission was that there be evidence that the potential patient presented a risk, either to self or to another person. Only 11% of the admission documents contained *any* suggestion that the person presented a risk. The admission documents disclosed such comments as "crying on phone" as apparent evidence of risk. To judge by the paperwork, therefore, 89% of unwilling admissions were in violation of the law.

A 1980 paper published by an Ontario psychiatrist[28] recommended flatly that psychiatrists *not* fully inform patients on admission about the medication they were prescribing, in clear contradiction to the requirements of the law. A 1982 investigation by Alberta's Ombudsman into allegations of serious physical abuse of patients by staff in one hospital resulted in documentation of many of the alleged abuses and the upholding of the dismissal of several staff members.[29] A similar situation surfaced in 1985 in a Quebec hospital where, along with sexual abuse and criminal activity by staff, patients had hoods placed over their heads and were tied in their chairs for stretches of many hours. One of the staff justified this by saying that, unlike normal people, psychotics did not perceive this as punishment.[30]

What does all this mean for the Bench and the Bar? I want to quote for you part of a 1984 judgment of a New York court.[31] The only change I am making to the Court's words is to replace the word "deaf" by the words "mentally disordered".

> *More than 100 years ago, Justice Oliver Wendell Holmes broke the accepted view of how legal rules are formed. He encourages us to use [i]n place of sterile, deductive reasoning* [...] *sensitive analysis and the weighting of competing policy considerations." Holmes postulated that:*

---

26. *Ibid.* at 21.

27. B. Perrin, "Involuntary Commitment to Mental Hospitals: Why?" (M.A. Thesis in Psychology, York University, 1973) [Unpublished].

28. W. O. McCormick, "'Informed Consent' in Psychiatric Practice", (Autumn 1980) Health Law in Canada, at 53-55.

29. Office of the Ombudsman, Province of Alberta, *Special Report of the Ombudsman. Ministerial Order Re: Alberta Hospital, Edmonton* (Edmonton: Office of the Ombudsman, 1982).

30. This was Hôpital Rivière-des-Prairies. A good running commentary can be found in the *Canadian Human Rights Advocate* beginning with the July 1985 issue.

31. *People* c. *Guzman*, 478 N.Y.S. 2d 455 (Sup. 1984), aff'd 555 N.E. 2d 259 (N.Y. 1990).

> [t]*he felt necessities of the time* [...] *even the prejudices which judges share with their fellow-men, have had a good deal more to do than the syllogism in determining the rules by which men should be governed. The law embodies the story of a nation's development through many centuries, and it cannot be dealt with as if it contained only the axioms and corollaries of a book of mathematics.*
>
> [...] *The law is a reflection of life and its realities and as Holmes taught us "*[t]*he life of the law has not been logic; it has been experience." It is imperative that we here recognize the crucial role which uninformed and irrational thinking has played in the perpetuation of this misapprehension about the [mentally disordered] and reject such thinking.* [...] *We, as members of a community which profoundly affects the lives of our fellow citizens, must always keep our minds open and alive to new information lest we fall victim once again to the same kind of static prejudiced thinking which has plagued our populace throughout the years with regard to such issues as race, gender and age.*[32]

I ask you to apply those words in considering the compelling *Charter* issues raised by the treatment accorded by the *Criminal Code* to the mentally disordered accused.

## II. THE CRIMINAL CODE AND THE INSANITY DEFENCE

Although the *Criminal Code* impacts on a mentally disordered accused in a number of ways, I want to deal in a *Charter* context with only one: findings of not guilty by reason of insanity.

The *Swain* case[33] considered by the Supreme Court of Canada deals with some of the *Charter* issues raised by the insanity defence. Mr. Swain questioned the right of the Crown to introduce evidence of insanity over the objections of the accused. He challenged the lack of discretion in the trial judge as to disposition following a finding of not guilty by reason of insanity. His arguments relied heavily on sections 7 and 9 of the *Charter*, and there were intervenors' arguments based on section 15.[34] However, I do not intend to review the *Swain* arguments here. Instead, I want to go much further, and suggest that the mere *existence* of the insanity defence violates the *Charter*.

---

32. *Ibid.* at 460-461.

33. *Supra* note 1.

34. Intervention by the Canadian Disability Rights Council, the Canadian Mental Health Association and the Canadian Association for Community Living (formerly the Canadian Association for the Mentally Retarded).

The insanity test has, of course, had numerous variations: The M'Naghten Rule,[35] the Brawner Rule,[36] the Durham Rule,[37] and so on. Our own Canada version, in a variant of the M'Naghten Rule defines the insane person as one who:

> *is in a state of natural imbecility or has disease of the mind to an extent that renders the person incapable of appreciating the nature and quality of an act or omission or of knowing that an act or omission is wrong.*[38]

Each variation has been an attempt to categorize individuals into those who are or are not, because of mental defect or disorder, morally responsible for their actions. The theory is that those who are not so responsible should not be punished, but should, where possible, be assisted by society to regain moral autonomy, while at the same time society is protected from further offences. That is a hard principle to dispute.

However, what makes perfect sense in theory does not in practice. In researching a paper some years ago,[39] I had the privilege of interviewing several of Toronto's most noted criminal lawyers about the insanity defence. Without exception, they informed me that they would *never* raise this defence except in the case of the most serious of offences, such as murder or multiple rape. Their reasoning was that the consequences to their client of pleading insanity were far harsher than the consequences of being found guilty. It is clear that a provision designed to protect and benefit accused persons is not perceived in that way by those who advocate for them.

I do not quarrel with the basic distinction between those who are and are not morally responsible for their conduct. My quarrel is with its particular formulation in the case of those with mental disorders. I suggest to you that in fact insanity, in the legal sense, is simply a specialized case of lack of *mens rea*, but one that carries with it penalties and infringements that follow in no other such case.[40] We have concealed this from ourselves by defining those penalties and infringements as benefits.

In Ontario not so long ago, a man got up in the middle of the night, dressed, got into his car, drove 23 kilometres and shot his parents-in-law. There was no apparent motive for this action; he was on very good terms with them. His successful defence in court, upheld on

---

35. Because of a disease of the mind, the person does not know the nature and quality of his acts or does not know that they are wrong.

36. As a result of mental disease or defect the person lacks substantial capacity to appreciate the wrongfulness of his conduct or to conform his conduct to the requirements of law. Propounded in *U.S.* c. *Brawner*, 417 F.2d 969 (D.C.Circ. 1972).

37. The unlawful act is the product of mental disease or mental defect. Propounded in *Durham* c. *United States*, 214 F.2d 862 (1954).

38. *Criminal Code*, R.S.C. 1985 c. C-46 as amended, s. 16(2).

39. C. McKague, "The Mentally Retarded Offender" (1979) [unpublished].

40. My comments about the consequences of an insanity finding are limited to indictable offences; they do not follow in summary conviction matters.

appeal,[41] was that he had been sleepwalking. The result? An outright acquittal. I am not saying that the outcome was incorrect. I am saying that I see little if any distinction in principle between those facts, and the same facts with the substitution of a psychotic episode for the sleepwalking. But in the latter case the result would have been mandatory incarceration, reviewed annually before an administrative advisory body, and a requirement that before release the offender demonstrate not only that he has recovered but also that it is in his interest and that of the public that he be released.[42] Further, in most of Canada that incarceration is routinely coupled with forcibly imposed psychiatric treatment.[43]

The artificial nature of this distinction is, ironically, pointed up in the concurring judgment of Brooke J. in the sleepwalking case in the following words:

> *The respondent is not criminally responsible, and accepting the evidence of the experts as the state of medical knowledge, I do not think society, through the criminal law, should require the respondent to suffer the possibility of an indefinite loss of his liberty at the pleasure of the Lieutenant Governor.*[44]

We as a society believe that the insane offender is also not criminally responsible, yet an indefinite loss of liberty *is* the outcome of that finding.

There is an intensified concern in the case of the accused who is found not guilty by reason of insanity on the grounds of — in the now offensive words of section 16 — "natural imbecility". If the prospects for returning a mentally disordered person to sanity are slim, in the case of a developmentally disabled person they are nonexistent. A finding of not guilty by reason of insanity is a life sentence.

I suggest that the theory fails because it is based on faulty premises. In light of my introductory remarks, I ask you to examine the premises of the insanity defence.

Those include the following: that we can accurately distinguish between sane and insane persons; that we can discover the nature of the mental disorder; that we can and should assist the person to regain sanity and lessen the chances of a new offence; and that in the process of providing treatment the benefit done to the person will outweigh any harm. Those premises bear little relation to the realities I have described above.

## III. THE CHARTER AND THE INSANITY DEFENCE

---

41. *R.* c. *Parks*, (1990) 73 O.R. (2d) 129 (C.A.).

42. *Criminal Code*, s. 619(5)(d).

43. For a detailed (if slightly outdated) account of provincial legislation governing treatment of people held on Warrants of the Lieutenant Governor, see H. Savage and C. McKague, *Mental Health Law in Canada* (Toronto: Butterworths, 1987).

44. *Supra* note 41, at 148-149.

In *Charter* terms, I suggest to you that a finding of not guilty by reason of insanity, and the consequences that flow from that decision, violate all of sections 7, 9 and 15.

It is unquestionable that the individual acquitted on the grounds of insanity is deprived of liberty, and that in most of Canada he or she is also deprived of security of the person because of the imposition of often unwanted medical treatment. The section 7 issue then reduces to whether the deprivation is in accordance with the principles of fundamental justice.

The Supreme Court has told us clearly, in the *B.C. Motor Vehicles* case,[45] that "fundamental justice" is more than procedural justice; it has substantive content.[46] The procedures to which mentally disordered offenders are subjected have been the subject of massive study by the Law Reform Commission of Canada and the Department of Justice of Canada, both of which have proposed sweeping reforms.[47] Some of those reforms now exist as a draft bill, and there is no doubt that if implemented they would do much to answer procedural concerns. I shall therefore not deal with procedural issues here,[48] but shall argue that it is substantively not in accordance with fundamental justice that an individual believed not to be criminally responsible for his actions should receive other than an outright acquittal.

First, consider the issue of identification of an accused as "sane" or "insane". This is certainly not easy in many cases, and our courts have engaged in a great deal of hair-splitting. In attempting to define "disease of the mind" they have distinguished between transient and longer-term mental disturbances,[49] between internally and externally caused disturbances,[50] between self-induced and otherwise-induced impairment,[51] between insane and

45. *Reference Re S. 94(2) of the Motor Vehicles Act B.C.*, [1985] 2 S.C.R. 486, 18 C.R.R. 30, 69 B.C.L.R. 145, 24 D.L.R. (4th) 536.

46. *Per* Lamer J. at S.C.R. 501-503, 512-513; *per* Wilson J. at 523, 530-532.

47. Law Reform Commission of Canada, *Report to Parliament on Mental Disorder in the Criminal Process* (Ottawa: Minister of Supply and Services Canada, 1977); G. Sharpe (Project Chief), *Mental Disorder Project Criminal Law Review: Final Report* (Ottawa: Department of Justice, 1985).

48. For an examination of procedural concerns, see Savage and McKague, *op. cit.*, note 43, especially Chapter 2, "LGWs: The Unwarranted Warrants".

49. *Cooper* c. *R.*, [1980] 1 S.C.R. 1149, 51 C.C.C. (2d) 129, 13 C.R. (3d) 97; *R.* c. *Rabey*, (1977) 37 C.C.C. (2d) 461, 79 D.L.R. (3d) 414 (Ont.C.A.), aff'd [1980] 2 S.C.R. 513, 15 C.R. (3d) 225, 54 C.C.C. (2d) 1, 114 D.L.R. (3d) 193, 32 N.R. 451.

50. *R.* c. *Rabey*, *supra* note 49; *R.* c. *Oakley*, (1986) 24 C.C.C. (3d) 351 (Ont. C.A.).

51. *Cooper* c. *R.*, *supra* note 49.

non-insane automatism,[52] among different types of delusions,[53] between psychopathy that falls within the insanity definition and psychopathy that does not.[54]

These distinctions are not only of little moral relevance but also, given the parlous state of psychiatric assessment, of highly questionable applicability in a particular case. Yet our courts strive mightily to apply them, and depending on the answer an accused goes to prison for a fixed term, goes to hospital for an indefinite term, or returns to the community. Even worse, there are fashions in applying the definition. Before the 1970s, psychopathy was generally not regarded as falling within the category of insanity, because it was general knowledge that it could not be cured; psychopathic offenders therefore went to prison. In Ontario, at least, when it appeared there was a program that has some hope of cure, the courts began finding psychopaths insane. When that program failed, psychopaths once again returned to the mainstream, and were convicted.

I have already discussed the almost total inability of anyone to assess the likelihood of a further offence, as well as the roughly one in three chance of significant benefit and the serious risks run by people undergoing certain common psychiatric treatments.

How can it be in accordance with the principles of fundamental justice that the verdict in the case of a particular accused depends on a judgment made on such an unreliable foundation, and with such an uncertain outcome? We are, to quote the title of one study of the problem, "flipping coins in the courtroom".[55]

Further, I would argue that the uncertainties are of such proportion that to detain anyone on this basis constitutes arbitrary detention contrary to section 9 of the *Charter*.

My section 15 concerns should be self-evident, The *Criminal Code* and the case law arising from it say flatly that, among those offenders who are not criminally responsible for their actions, one group shall be treated differently, and shall be treated differently because of a mental disability. McIntyre J., in the *Andrews* decision,[56] described discrimination in this way:

> *I would say then that discrimination may be described as a distinction, whether intentional or not, but based on grounds relating to personal characteristics of the individual or group, which has the effect of imposing burdens, obligations, or disadvantages on such individual or group not imposed upon others, or*

---

52. *R.* c. *Revelle*, (1979) 48 C.C.C. (2d) 267 (Ont. C.A.), aff'd [1981] 1 S.C.R. 576, 61 C.C.C. (2d) 575, 21 C.R. (2d) 162.

53. *R.* c. *Landry*, (1988) 66 C.R. (3d) 158 (Que. C.A.); *R.* c. *Abbey*, [1982] 2 S.C.R. 24, 68 C.C.C. (2d) 394, 29 C.R. (3d) 193, *R.* c. *Kirby*, (1985) 21 C.C.C. (3d), 47 C.R. (3d) 97 (Ont. C.A.); *R.* c. *Swain*, *supra* note 1.

54. *Cooper* c. *R.*, *supra* note 49; *R.* c. *Simpson*, (1977) 35 C.C.C. (2d) 337, 77 D.L.R. (3d) 507 (Ont. C.A.); *Kjeldsen* c. *The Queen*, (1981) 64 C.C.C. (2d) 161, 24 C.R. (3d) 289 (S.C.C.).

55. Ennis and Litwack, *op. cit.*, note 5.

56. *Andrews* c. *Law Society of British Columbia*, [1989] 1 S.C.R. 143, [1989] 2 W.W.R. 289, 34 B.C.L.R. (2d) 273, 10 C.H.R.R. D/5719, 36 C.R.R. 193, 56 D.L.R. (4th) 1, 91 N.R. 255.

> *which withholds or limits access to opportunities, benefits, and advantages available to other members of society. Distinctions based on personal characteristics attributed to an individual solely on the basis of association with a group will rarely escape the charge of discrimination, while those based on an individual's merits and capacities will rarely be so classified.*[57]

All the evidence is that this differential treatment of the insane offender constitutes not a benefit but a deprivation, imposing burdens, obligations and disadvantages upon him or her that are not imposed on someone judged sane. Those burdens are imposed because the individual belongs to the arbitrary, elastic, ill-defined group of people currently judged to fall within the section 16 definition. There is not individualized assessment of risk. There is not examination of individual potential for recovery (in fact, for the developmentally disabled individual, this potential is known to be nil). These are not even recognized as criteria by the courts.[58] In *Swain* the Ontario Court of Appeal said explicitly:

> *An acquittal on account of insanity is retrospective and is not concerned with present mental illness, present dangerousness or present treatability*.[59]

And there is acceptance of the stereotypical views of society about mentally disordered people. To quote that judgment again:

> [T]*he finding of not guilty by reason of insanity raises what I accept to be a reasonable concern that the accused may remain a danger to the public* [...].[60]

Of course, people can be, and are, found not guilty by reason of insanity of non-violent offences. The only at all reliable predictor of future violence is past violence. On what grounds, other than mythical, could one conclude that those individuals present any danger whatsoever to the public?

And why should our concern for the safety of the public be limited to the case of the insane offender? On a statistical basis, society has much more to fear from the sane violent offender; there are many more of them, and they are as likely or more likely to repeat the offence. But we do not implement preventive detention for sane individuals without great safeguards. The *Criminal Code* does provide for the indefinite detention of "dangerous offenders",[61] but only where it is established that the offender has committed a serious personal injury offence, and that the offender is a continuing threat to the public or to another person.[62] No such test is applied in the case of the insane offender.

---

57. *Ibid.* at S.C.R. 174-175.

58. See, for instance, *R.* c. *Oakley*, *supra* note 50; *R.* c. *Swain*, *supra* note 1.

59. *Supra* note 1 at O.R. 632.

60. *Ibid.* at O.R. 639.

61. See sections 753-761.

62. The test in section 753 is as follows:

> "(a) that the offence for which the offender has been convicted is a serious personal injury offence [...] and

Suppose we did abolish the insanity defence. What would result? All offenders, whatever their state of sanity at the offence, would be acquitted or convicted on the same basis: the presence or absence of *actus reus* and *mens rea*. The person who was found guilty would go to prison — and I would hope would have available there the best psychiatric services we could provide, on a voluntary basis. The person who was found not guilty would be freed.

And here, of course, is where section 1 of the *Charter* enters the picture. Consider the worst possible case from the public's point of view — an acquittal because of lack of *mens rea* of someone who has committed repeated violent offences, and may reasonable be presumed likely to do so again. Is this a situation in which even *Charter* rights should be overridden for the public safety? Do the insanity provisions constitute "such reasonable limits prescribed by law as are demonstrably justifiable in a free and democratic society"?

This argument presupposes that there is no other way to deal with the risk, and that is simply not the case. Every province and territory in Canada has mental health legislation, and while much of that legislation also raises *Charter* concerns, it is more than adequate to handle the problem. A person who is believed, because of mental disorder, to present a serious risk to self or others may be admitted to hospital for assessment and detained involuntarily if the assessment supports that belief. And the various provincial Acts compare favourably with the *Criminal Code* under the section 1 test propounded by the Supreme Court of Canada in the *Oakes* case.[63] In brief, the *Oakes* test is, first, that the objective to be served by the impugned legislation must relate to societal concerns that are pressing and substantial in a free and democratic society, and second, that the means employed must be reasonable and demonstrably justified. That requires examination of proportionality, and the Court lays out a three-part test:

---

the offender constitutes a threat to the life, safety or physical or mental well-being of other persons on the basis of evidence establishing

(i) a pattern of repetitive behaviour by the offender, of which the offence for which he has been convicted forms a part, showing a failure to restrain his behaviour and a likelihood of his causing death or injury to other persons, or inflicting severe psychological damage on other persons, through failure in the future to restrain his behaviour;

(ii) a pattern of persistent aggressive behaviour by the offender, of which the offence for which he has been convicted forms a part, showing a substantial degree of indifference on the part of the offender respecting the reasonably foreseeable consequences to other persons of his behaviour, or

iii) any behaviour by the offender, associated with the offence for which he has been convicted, that is of such a brutal nature as to compel the conclusion that his behaviour in the future is unlikely to be inhibited by normal standards of behavioural restraint, or

(b) that the offence for which the offender has been convicted is a serious personal injury offence [...] and the offender, by his conduct in any sexual matter including that involved in the commission of the offence for which he has been convicted, has shown a failure to control his sexual impulses and a likelihood of his causing injury, pain or other evil to other persons through failure in the future to control his sexual impulses."

63. *R.* c. *Oakes*, [1986] 1 S.C.R. 103, 26 D.L.R. (4th) 200, at S.C.R. 138-140.

> *First, the measures adopted must be carefully designed to achieve the objective in question. They must not be arbitrary, unfair or based on irrational considerations. In short, they must be rationally connected to the objective. Second, the means, even if rationally connected to the objective in this first sense, should impair "as little as possible" the right or freedom in question* [...]. *Third, there must be a proportionality between the effects of the measures which are responsible for limiting the Charter right or freedom, and the objective which has been identified as of "sufficient importance".*

The objectives of the *Criminal Code* insanity provisions are twofold: to assist the offender to overcome his or her mental disorder, and to protect society. Assuming for the sake of argument that these objectives are of sufficient importance to warrant section 1 protection,[64] how does the *Criminal Code* compare with provincial and territorial mental health legislation on the proportionality test?

## IV. OPTIONS TO THE PRESENT CRIMINAL CODE INSANITY DEFENCE

The twelve provinces and territories of Canada have twelve different statutes dealing with civil commitment and treatment. These statutes vary greatly, and it would serve no useful purpose to review each in detail. I am therefore going to take as my standard for comparison the *Uniform Mental Health Act*,[65] adopted by the Uniform Law Conference in August 1987 with the participation of seven of Canada's twelve jurisdictions, and providing some sort of common Canadian standard for dealing civilly with mental disorder.

The standard for initial detention under the *Criminal Code* is that the individual, whatever his or her current state of mind, has committed an indictable offence (violent or non-violent) while legally insane. The standard in the *Uniform Mental Health Act*[66] is that there is reasonable cause to believe that, because of a mental disorder, the individual has recently threatened or attempted bodily harm to self or others or caused someone to fear bodily harm, or has recently shown an inability to care for himself or herself, and that a physician or other designated health professional is of the opinion that, because of the mental disorder, the

64. I would in fact hold that only the second objective — that of protecting society — meets the test, and that one cannot deprive an individual of *Charter* protections in order to benefit that individual.

65. Uniform Law Conference. Many of the draft Act's provisions are reflected in the legislation of several provinces, especially Ontario, Manitoba and Nova Scotia.

66. *Uniform Mental Health Act*, s. 3(1). This is the test to be applied by a physician or health professional. Similar tests are laid out for an order by a judicial officer (s. 4) and for apprehension by a police officer (s. 5).

individual presents a serious risk to self or others.[67] This test bears considerably more rational connection to the objectives than that in the *Criminal Code*.

To continue detention under the *Uniform Mental Health Act*, the physician has the onus of demonstrating continuing risk of serious bodily harm or serious physical impairment.[68] Under the *Criminal Code* it is unclear where the onus lies; the test is that the person has recovered, and that it is in his or her interest and in the interest of society that he or she be released. The latter test impairs the patient's freedom much more than the former, requiring not just absence of risk to self or others but total recovery and positive benefit to self and others in order to justify release. I suggest that this is grossly disproportionate and cannot meet the *Oakes* requirement of impairing as little as possible the right in question.

Procedures can be amended, and, as already mentioned, the federal government has indicated some willingness to repair the procedures around review of Warrants of the Lieutenant Governor. At present, however, the procedural safeguards accorded civilly committed patients are considerably higher than the almost non-existent protections for individuals on warrants. In most of Canada, civilly committed patients are entitled to frequent judicial or quasi-judicial hearings with full rights of appeal.[69]

## CONCLUSION

---

67. The precise wording of the test is:

> "A physician or designated health professional who has examined a person may recommend involuntary psychiatric assessment of the person, if the physician or designated health professional is of the opinion that the person is apparently suffering from mental disorder and if one of the following two conditions is also fulfilled:
>
> 1. The physician or designated health professional has reasonable cause to believe that the person, as a result of the mental disorder,
>
> i. is threatening or attempting to cause bodily harm to himself or herself, or has recently done so,
>
> ii. is behaving violently towards another person, or has recently done so, or
>
> iii. is causing another person to fear bodily harm, or has recently done so,
>
> and the physician or designated health professional is of the opinion that the person, as a result of the mental disorder, is likely to cause serious bodily harm to himself or herself or to another person.
>
> 2. The physician or designated health professional has reasonable cause to believe that the person, as a result of the mental disorder, shows or has recently shown a lack of ability to care for himself or herself and the physician or designated health professional is of the opinion that the person, as a result of the mental disorder, is likely to suffer impending serious physical impairment."

68. See section 11.

69. Savage and McKague, *op. cit.*, note 43.

Both in substance and in process, the *Criminal Code* provisions fall far short of the sort of proportionality demanded by the *Oakes* test. I would conclude by suggesting to you that the insanity defence, in Canadian society and elsewhere, has no supportable rationale. However well-intentioned it might have been originally, it has become a sham. It is society's way of persuading itself that it has dealt justly with the person who is not only "bad" but "mad", of getting a person of whom we have a superstitious fear off the street and at the same time salving our collective conscience by asserting that we have provided him or her a benefit. Society's true attitude to the question of whether a particular person should be convicted or found not guilty by reason of insanity is that the preferable verdict is the one that will keep the person locked up longer. For example, when John Hinckley was acquitted on the grounds of insanity of an attempt to assassinate the President of the United States, there was a great public outcry that he had "got off". However, in Toronto a few years ago, when a juvenile offender was found guilty of murder even though Crown and defence had both argued he should be acquitted on insanity grounds, the outcry was even greater. The public was not concerned with whether the young man was truly responsible for his actions; it was concerned with the fact that a conviction under the *Young Offenders' Act* would result in a maximum of three years' imprisonment, while an insanity finding would have led to indeterminate detention.

It is time for us to take a hard look at whether there is any basis in reality for retaining section 16 of the *Criminal Code* and those sections related to it. It is time to throw off outmoded beliefs and received wisdom, and to treat all offenders with the same impartial justice that we presently try to accord only to those who do not bear the stigma of mental disorder.