THE CRIMINAL PROCESS AND MENTAL DISORDER

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The authors of this Working Paper deserve great credit, and while I concur with many of their views, I respectfully disagree in some areas. However, before commenting on those specific parts of the report with which I disagree, I wish to make these general observations. While section 16 of the Criminal Code [1] relieves an accused person of criminal responsibility for an offence committed while he was insane, and goes on to limit insanity to a disease of the mind that renders him incapable of appreciating the nature and quality of an act or omission or of knowing it was wrong, it does not draw a clear line between those suffering from mental disorder who fall within the provisions of section 16 and those who fall outside. Indeed, those outside the section comprise a broad spectrum of mental disorders. At one end are those who almost, but not quite, come within the cloak of criminal irresponsibility, followed by persons afflicted by gradual shades of disorder, culminating in the almost normal. In this broad spectrum are an enormous number of offenders suffering from a variety of mental disorders; more important, the individual conditions of the majority of these patients also varies. Sometimes it is cyclical, at other times it can be surprisingly episodic. Let us not delude ourselves that the problems of the mentally ill who fall within the criminal process are static. The mentally ill vary infinitely. They respond to their surroundings. Some get worse and may never recover. Others get better, especially if they receive psychiatric treatment. But a special torment is reserved for those who happen to be in a federal penitentiary, for they are tied to a sentence. If they deteriorate on the ranges, they may be sent to a psychiatric service within the institution. There they may recover only to be returned to the range. Again they deteriorate, and again off they go to the psychiatric service. This I call revolving door psychiatry. It is destructive to the patient and discouraging to the psychiatrist.

One psychiatrist was prompted recently to recommend that psychiatric treatment in prison be postponed to the period just before discharge, when the prisoner-patient, having received the benefits of psychiatry, could be released into the community. It is perhaps this feature that accounts for the low recidivism rate of Lieutenant Governor's warrant cases in Ontario. Arriving in the maximum security division of the Ontario Psychiatric Facility

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[1] R.S.C. 1970, c. C-34.

at Penetang on a Lieutenant Governor's warrant because he was found not guilty by reason of insanity, the patient discovers he is on a real life warrant. Surrounded by an intensive therapeutic milieu, he soon makes up his mind that his own insight is essential to recovery. His therapy varies according to his illness. As he is rehabilitated he can look forward to an eventual transfer to a regional hospital on a loosened warrant, where over a period of years he can take his place in society and perhaps achieve the vacation of his warrant. Of course, some persons may be so ill as to require permanent maximum security, while others will prefer to remain under the control of the regional hospital, while working and living in the community. The recidivism rate of those released under Lieutenant Governor's warrants in Ontario is nine per cent. This process may be called the hospitalization route to rehabilitation for the mentally disordered, and if we are to accept the recommendations of the Commission and institute a system of hospital orders, [2] Ontario provides a model.

However, I do not agree with the recommendations of the Commission that psychiatric treatment should occur only with the consent of the prisoner. [3] Unlike all other illnesses, mental disorder deprives the patient of the ability to appreciate his illness and the need for treatment. He may be psychotic, hallucinating or so melancholy that he wants to die. He is often anti-social, suspicious, or dangerous and aggressive to himself and others. Are we to make him "king" of his treatment and compel dedicated doctors and other personnel to stand aside, awaiting his decision, when they could relieve his symptoms and often restore his health with the wonders of modern therapy. It is my view that where a man is mentally ill and requires treatment in an institution, it is the obligation of the superintendent of the institution to give him the appropriate treatment and it is the obligation of the patient to accept it. To those civil righters imbued with the doctrine of informed consent before treatment of the mentally ill, I pose this question: "Have you ever compared the alleged cruelty of treatment with the cruelty of non-treatment?" Let us never evolve a system where the patient's lawyer is inserted between the patient and his doctor. On that day confidence between the doctor and patient will be lost. When a patient can say to a doctor, "I won't take this medicine or treatment until I see my lawyer", that busy doctor is going to become discouraged and cease to try. Indeed, his services are so important elsewhere that he may refuse to practise in our institutions.

There is another disability in corrections. Sentences are definite. The prisoner knows his parole date and, unlike his counterpart under a Lieutenant Governor's warrant, the prisoner knows he will be released. Some will say that since treatment for mental illness is arduous, why bother? The patient may even enjoy his irresponsibility and dream of continuing his

[2] LAW REFORM COMMISSION OF CANADA, THE CRIMINAL PROCESS AND MENTAL DISORDER, WORKING PAPER 14, at 46-49 (1975).

[3] *Id.* at 47.

deviant conduct. In my opinion, the prisoner must know that his release will be postponed so long as he is a danger to society by reason of his mental disorder.

Asking "How dangerous the madman?" the authors conclude: "No conclusive correlation has been found between mental disorder and dangerous, violent conduct." [4] I disagree. Most laymen know that what a man has done repeatedly in the past, he is apt to do again; and every psychiatrist has a healthy respect for his patient's psychiatric history for violence. While psychiatrists will tell you that their most difficult task is to predict whether an individual is dangerous, they can say that certain psychiatric disorders are more prone to danger than others.

The Commission seems to be of the view that "[p]robably as a result of the virtual abolition of capital punishment, the decreasing severity of sentences and the introduction of parole and probation, the insanity defence is now raised so infrequently as to be statistically unimportant". [5] In Ontario the opposite seems to be taking place. Perhaps it is because the treatment of Lieutenant Governor's warrant cases in Ontario facilities offers a much greater opportunity for rehabilitation than the subculture of a penitentiary.

Fitness to Stand Trial

The Commission states: "We feel the automatic detention of unfit accused under lieutenant governor's warrants in psychiatric facilities for indeterminate periods is unjustified." [6] I was unaware that this existed anywhere in Canada. Each accused found unfit to stand trial in Ontario is subject to a Lieutenant Governor's warrant and promptly enters hospital, where everything is done to make him fit to stand trial. His case is reviewed yearly, and more often if indicated. The Commission has set forth criteria for fitness [7] with which I agree, but there is one I would like to emphasize. It concerns the lawyer for the accused. If he will undertake to accept instructions and defend the case, that becomes a most important consideration in the opinion of the Ontario Advisory Review Board, and we are obliged to the Ontario Legal Aid System for making leading counsel available. It is important to the accused's mental health that he get the charge behind him, even if his appearance in court results in his being returned to hospital as not guilty by reason of insanity. The fear of an innocent man, forgotten and languishing in an Ontario psychiatric facility, is illusory. If an accused is at all fit, he is returned for trial. If he is unfit, his mental condition is so bad that he needs continued supervision. I doubt if there are ten people in Ontario belonging to the rare class of accused persons unlikely ever to be fit and charged with an offence that the Attorney

[4] *Id.* at 18-19.
[5] *Id.* at 31.
[6] *Id.* at 40.
[7] *Id.* at 36.

General can *nolle prosse*. The latter is often done, the patient being then certified under the Mental Health Act. It is my personal opinion that the thinking in this area has been muddled by what has happened south of the border, where men awaiting trial have been permitted to remain in custody for years. It does not happen here.

Psychiatric Evidence, Reports and Remands

Psychiatry and law are on a collision course. Law considers a man either sane or insane and draws a line by section 16 of the Code.[8] Law considers a man either responsible or not responsible according to its criteria. Psychiatry sees no such line and thinks law is out of touch with modern medicine. Psychiatry sees the whole man as a product of his genes, his environment, his total mental faculty and his disorders. In the vast complexity of this human machine it tries to discover the reason for the impugned conduct. The forensic psychiatrist is quite prepared to assist in the post mortem of the past misconduct, even though rather frustrated by the limitations of the adversary method. Law limits the role of the psychiatrist and obliges him to observe certain rules of non-disclosure imposed upon him by the legal system. In his daily life a psychiatrist is not a protagonist. He is an active collaborator with his fellows in discovering the causes of mental illness and its prognosis. He works in a team. But in court he is tied to one adversary or the other.

At the outset of a criminal case, if the accused is referred to him by the court for examination, the psychiatrist's sole duty is to ascertain fitness. That is not difficult. If he is retained by the defence, the psychiatrist's position is much different. Counsel want to know very much more. "Have we a defence of insanity?" "Can we plead automatism?"

Assume the accused has been found fit and the trial is proceeding. Without the consent of the accused's counsel, the Crown psychiatrist can make no examination at all and must confine himself to observations made in court and to such other material as the Crown provides; while his brother psychiatrist for the defence has had many psychiatric examinations, and perhaps also a psychologist and a complete psychiatric work-up, to assist him. Is it any wonder that psychiatrists find all this rather confusing, especially when it produces conflicts of opinion that could be resolved quite quickly by adequate examination and conferences. Why should the courts insist on an archaic method of dispute resolution when the same questions are decided scientifically in modern hospitals with every diagnostic aid and discipline? The legal system which ties the behaviour sciences to an adversary win-lose system requires careful examination.

As Professor Allen Stone of Harvard says, "the psychiatrists are tired of being the janitors to the legal system". They want either to take a more meaningful role in assisting the courts or not be troubled. The Canadian

[8] R.S.C. 1970, c. C-34.

Psychiatric Association and the Ontario Psychiatric Association have each formed forensic sections, and I think many of the questions posed by the Commission will be settled in the near future. Perhaps the first step will come when the forensic psychiatrists in a body say: "We'll be glad to accept your instructions, so long as we are free to consult with the psychiatrists on each side and make such examinations and tests as are indicated in the interest of truth."

Finally, we as judges and lawyers should start by admitting our ignorance of modern psychiatry and the therapies available to the mentally disordered. It is time we stopped patronizing a learned profession by accusing them of using language we have never troubled to understand. How many of us are familiar with the *Manual for Classification of Psychiatric Diagnosis*,[9] based upon the international classification of mental disorders? It is simple and easy to understand. A quick examination will disclose the realities of the various illnesses and help us to understand them so that with better wisdom we can seek humanitarian solutions. We will quickly learn that we are not being very realistic in referring a patient for mental examination and leaving it to the doctor to discover what we want. Instead, we should enunciate our problem and indicate the areas in which we would like assistance. Furthermore, we will learn that a jail is no place for a meaningful examination, and that an out-patient clinic can rarely do much except in mild cases. If a psychiatric examination is worth doing, it is worth doing well in a hospital, where every diagnostic aid is available, including a team of specialists. Only then will we get the real help we need. But there will be a catch in it. We will send fewer people to jail. Instead, we will evolve a system of hospitalization and coercive after-care which will ensure rehabilitation. Today we know that the most deleterious aspect of corrections is the subculture into which we insert those convicted. We have an ever-mounting belief that any real improvement in criminal law must first await improvement in corrections. On the horizon there is only one ray of hope, and that is modern psychiatry, which is intimately involved with the prisoner-patient. Psychiatry has just scratched the surface but it promises much. That is not all. The courts and lawyers should be involved. Corrections must be an ongoing process. A sentence should be subject to revision if there is to be any real hope of the subject's reforming himself.

[9] STATISTICS CANADA, HEALTH AND WELFARE DIVISION, MENTAL HEALTH SECTION, MANUAL FOR CLASSIFICATION OF PSYCHIATRIC DIAGNOSIS (1968).