MENTAL ABNORMALITY AND THE CRIMINAL LAW*

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Nature of Relationship

Under the present law of Canada mental abnormality affects criminal law and its administration in the following ways:[1]

1. A person who is "insane" when brought on for trial is regarded as unfit to stand trial and cannot be tried on a charge of a criminal offence.[2]

2. A person who is "insane" as defined in section 16 of the Criminal Code is not criminally responsible for his conduct while he is in that condition. A person who acts in a state of unconscious automatism in a manner which would ordinarily be criminal may be treated as "insane" within the meaning of section 16, or may be regarded as simply not having been engaged in voluntary conduct and therefore not guilty of a criminal offence.

3. A person who is not "insane" but is "mentally abnormal" may for that reason be incapable of the planning and deliberation required for guilt on a charge of capital murder, and perhaps incapable of forming the intent necessary for commission of other offences.[3]

4. A woman who by a wilful act or omission kills her newly born child while the "balance of her mind is disturbed" as a result of giving birth or lactation is guilty not of murder or manslaughter but of infanticide.[4]

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1 See generally: Barry Swadron, *Detention of the Mentally Disordered* (1964), cc. 8-12; G. A. Martin, "Insanity as a Defence" (1965-6), 8 Crim. L.Q. 240; J. LI. J. Edwards, "Automatism and Social Defence" (1965-6), 8 Crim. L.Q. 258; H. H. Bull, "Fitness to Stand Trial" (1966), 8 Crim. L.Q. 290; *Report of Royal Commission on the Law of Insanity as a Defence in Criminal Cases* (1956).

2 *Criminal Code* (1953-4), 2 & 3 Eliz. II, c. 51, ss. 524-6 (Can.).

3 *More v. R.*, [1963] S.C.R. 522; 1 C.C.C. 289; 41 C.R. 98; see G. A. Martin, *ibid.*, at p. 254, and "Necessity of Proof of Wrongful Intent in Criminal Cases" (1961), 4 Crim. L.Q. 63, at p. 67; *Record 2nd Commonwealth & Empire Law Conference*, 276; see also *R. v. Lenchitsky*, [1954] Crim. L.R. 216.

4 *Criminal Code* (1953-4), 2 & 3 Eliz. II, c. 51, ss. 204, 208.

5. On a charge of murder, where provocation sufficient to deprive an ordinary person of the power of self-control is supported by evidence, mental abnormality of the accused person is then to be taken into account in determining whether he was deprived of self-control.[5]

6. Mental abnormality of any kind is relevant to sentence when the court exercises discretion in awarding punishment.[6] For example, a mentally abnormal person placed on suspended sentence with or without probation may be required to undergo appropriate treatment.[7] On the other hand, a "dangerous sexual offender" must in appropriate circumstances be sentenced to life imprisonment under the guise of preventive detention.[8]

7. A person found to be mentally ill or mentally deficient while in a prison may be detained by order of the Lieutenant-Governor, usually in a mental hospital.[9]

8. A person found to be mentally ill on receipt in a penitentiary may be rejected by the penitentiary authorities.[10]

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5 *Criminal Code*, *ibid.*, s. 203; *Taylor v. R.*, [1947] S.C.R. 462; 89 C.C.C. 209; 3 C.R. 475; the English rule appears to preclude such consideration: *R. v. McCarthy* (1954), 38 Cr. App. R. 74.

6 *Criminal Code*, *ibid.*, s. 621; *R. v. Bezeau*, [1958] O.R. 617; 122 C.C.C. 35; *R. v. Roberts*, [1963] 1 O.R. 280; [1963], 1 C.C.C. 27; 36 D.L.R. (2d) 696; 39 C.R. 1.

7 *Criminal Code*, *ibid.*, s. 638(2); *cf. R. v. Jones*, [1956] O.W.N. 396; 115 C.C.C. 723; 23 C.R. 364, and *R. v. Kangles* (1960), 129 C.C.C. 138, with *R. v. Sheppard and Mitchell*, [1966] 1 C.C.C. 230; for information concerning the extent of use of probation under psychiatric treatment in Ontario see *Annual Reports of Forensic Clinic, Toronto Psychiatric Hospital*, now Clark Institute of Psychiatry, U. of T., 1958-66, and *Annual Reports Ontario Department of Health, Mental Health Branch.*

8 *Criminal Code*, *ibid.*, ss. 659(b) and 661. This is a most unsatisfactory sentence. It is served in an ordinary penitentiary, usually a maximum security institution. The inmate is usually subjected to the ordinary penitentiary regime, although a few have been kept in psychiatric wards or in segregation. Although parole is possible, it is life parole. At least two teen-age boys have been sentenced to this form of life imprisonment for indecent assaults on children. A number of, but not all, such offenders might be dealt with by an indeterminate "mental hospital" sentence recommended in this paper. The remainder should have determinate sentences.

9 *Criminal Code*, *ibid.*, s. 527; see *Re Brooks' Detention* (1961), 38 W.W.R. 51; and Swadron, *Detention of the Mentally Disordered* (1964), pp. 332-7.

10 *Penitentiary Act* (1960-1), 9 & 10 Eliz. II, c. 53, s. 19(2) (Can.). A grotesque situation, which would have been funny if it had not been tragic, occurred some time ago in a western province. On refusal of an offender at a penitentiary, the provincial authorities at first refused to take him back, and he was for a time left literally at large on the street.

9. By arrangement between the national and provincial governments inmates of penitentiaries may be transferred to mental hospitals for treatment during their imprisonment.[11] A similar transfer may occur where the inmate is in a provincial penal institution.[12]

10. The remand for observation of persons in custody pending trial or preliminary hearing,[13] although intended to be a diagnostic measure for the information of the court, may lead to the accused's being certified as mentally ill and detained in a mental hospital and removed from the criminal process. In some such cases, the criminal charge pending against the accused is not proceeded with.

Meaning of Terms

We refer to different mental conditions by the phrase "mental abnormality" in these several contexts. For example, our criminal law clings to the word "insanity" which was long ago discarded as irrelevant and meaningless in medical science.[14] The confusion is confounded because the word "insane" is used in the Criminal Code in two quite different senses, one in relation to fitness to stand trial and the other in relation to immunity from criminal responsibility. As a test of fitness to stand trial, the issue is whether the accused is capable of understanding in some degree the charge against him and the nature and possible consequences of the proceedings and is able to "instruct counsel" in the preparation and conduct of his defence.[15] In reference to immunity from responsibility, insanity is related by section 16 of the Code to incapacity to appreciate the nature and quality or the "wrongfulness" of conduct, resulting from either "natural imbecility" or "disease of the mind".[16] The medical profession has pretty well abandoned the use of the term "natural imbecility" but no confusion arises

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11 *Penitentiary Act*, *ibid.*, s. 19(1).

12 *Criminal Code* (1953-4), 2 & 3 Eliz. II, c. 51, s. 527; for reference to provincial legislation authorizing transfer see Swadron, *Detention of the Mentally Disordered* (1964), pp. 428-435.

13 *Criminal Code*, *ibid.*, ss. 451(c), 524(1a) (as enacted by (1960-1), 9 & 10 Eliz. II, c. 43, s. 22), 710(5): *Fawcett v. Attorney-General of Ontario*, [1964] S.C.R. 625; [1965] 2 C.C.C. 262; 45 D.L.R. (2d) 579; 44 C.R. 201; *Swadron*, *ibid.*, c. 8; *cf.* Ontario and Saskatchewan legislation cited in c. 8, pp. 262-9.

14 *Criminal Code*, *ibid.*, ss. 16, 523-6; see, for example, Wily and Stallworthy, *Mental Abnormality and the Law* (1961), pp. 19-20; Whitlock, *Criminal Responsibility and Mental Illness* (1963), c. 1.

15 See H. H. Bull, "Fitness to Stand Trial" (1965-6), 8 Crim. L.Q. 290.

16 See G. A. Martin, "Insanity as a Defence" (1965-6), 8 Crim. L.O. 240.

from its use. The phrase "disease of the mind", on the other hand, has caused difficulty.[17]

"Disease of the mind" corresponds roughly with the medical terms "mental disease" or "mental illness", but medical classification and terminology are not uniform. Medical concepts of mental abnormality, otherwise than in relation to mental defect, do not in any event correspond with either legal meaning of "insanity" as used in our Code. The broad band of mental abnormality which is the special concern of the behavioural scientist includes conditions some of which are and others which are not described generally as "mental diseases" or "mental illnesses". There is, indeed, one school of psychiatrists who deny the existence of "mental disease" as such.[18] They substitute expressions such as "an altered internal status of the individual with relation to his external world as interpreted by others". Although not generally accepted, their arguments are of value in emphasizing the fact that there is no clear line of distinction between mental illness and mental health.[19]

The following greatly simplified classification of mental abnormality appears to be generally accepted in medical science:[20]

1. States of greater or less mental defect or retardation, variously caused.[21]

2. "Psychotic states" or "psychoses", in which the patient has an acquired state of mental abnormality by which the personality is markedly altered so that he loses his normal appreciation of reality and may become deluded or suffer hallucinations, and he therefore feels, thinks and behaves in

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17 See, for example, Whitlock, *Criminal Responsibility and Mental Illness* (1963), pp. 4-5, 27-32; Toch, *Legal and Criminal Psychology* (1961), pp. 158-161; Roche, *The Criminal Mind*, c. 2.

18 Roche, in "Symposium on Criminal Responsibility and Mental Disease", and Cavanaugh, in "A Psychiatrist Looks at the Durham Decision", quoted by Burger J. in *Blocker v. U.S.* (1961), 288 F. 2d 853; Toch, *ibid.*, p. 159; see also Szass, "Psychiatry Ethics and the Criminal Law" (1958), 58 Col. L.R. 183. Medical science prefers apparently to distinguish between a "disease", which is a kind of entity with a reasonably definable cause and course, and an "illness" or "disorder" or "disability" which need not be so. For this reason the substitution of "disorder of the mind" for "disease of the mind" in *Criminal Code* (1953-4), 2 & 3 Eliz. II, c. 51 (Can.) appears to be appropriate.

19 Whitlock, *Criminal Responsibility and Mental Illness* (1963), p. 75, Wily and Stallworthy, *Mental Abnormality and the Law* (1961), pp. 19 *et seq.*

20 See Wily and Stallworthy, *ibid.*, pp. 26-7. There are many other similar classifications: see, for example, Katz, Goldstein and Dershowitz, *Psychoanalysis, Psychiatry and Law*, pp. 506-521.

21 Wily and Stallworthy, *ibid.*, c. 5.

ways not normal to him. Some psychoses are organic or physical in origin.[22] Others, described as "functional", where no evidence of related physical disorder is found, are apparently largely emotional in origin.[23]

3. Epilepsy includes a complex group of conditions resulting from a variety of causes, not necessarily accompanied by other mental abnormality. The patient may have any degree of intelligence; he may be a genius, like Julius Caesar.[24]

4. Neuroses are conditions in which the patient is disturbed by psychic or physical symptoms which represent his emotional reaction to his problems and difficulties. Although they affect conduct, neuroses do not prevent normal appreciation or reality and generally normal social behaviour, and do not cause delusions or hallucinations.[25]

5. There are also various abnormal personalities, such as:

(a) The psychopathic or sociopathic personality, variously defined, but usually marked by consistent failure to display evidence of a normal conscience, and apparent inability to learn from experience or profit from instruction or punishment. Psychopathy is often not accompanied by any other form of mental disorder.[26]

(b) Alcoholics or drug addicts who may but need not suffer from other mental disorder.[27]

(c) Sexual deviates, who likewise may but need not suffer from other mental disorder. Not all sexual offenders are deviates.[28]

(d) A woman suffering from the effects of childbirth or lactation may experience mental disorder, which may cause her to kill her child. I suggest that these tragic persons should not be convicted of any offence at all.[29]

In a sense, the phrase "disease of the mind" is irrelevant to medical science.[30] All mental abnormalities call for treatment

22 *Ibid.*, c. 6.

23 *Ibid.*, c. 7.

24 *Ibid.*, c. 9.

25 *Ibid.*, c. 8.

26 *Ibid.*, pp. 186-196.

27 *Ibid.*, pp. 196-223.

28 *Ibid.*, c. 11.

29 *Criminal Code* (1953-4), 2 & 3 Eliz. II, c. 51, s. 204 (Can.); Wily and Stallworthy, *ibid.*, pp. 321-5.

30 Wily and Stallworthy, *ibid.*, pp. 19-22.

although some do not respond readily or at all to any treatment so far devised. Except for the distinction between mental abnormalities of organic or of functional origin, it is impossible to find clearly defined boundaries marking off one kind of disorder from another.[31] The accepted classification of functional disorders is largely based on symptoms. One patient may display symptoms suggesting more than one category. The distinction between neuroses and psychoses may in certain cases be only a matter of degree and there may be differences of professional opinion over the correct classification.

Except for those who deny the existence of mental illness, psychiatrists generally agree that functional psychoses are "diseases of the mind."[32] Some but not all describe organic psychoses as "diseases of the brain" rather than "of the mind" because of their physical aspects. The courts now tend to regard them all as diseases of the mind.[33] Epilepsy creates more difficulty in classification, because many epileptics do not exhibit symptoms of mental abnormality except while undergoing epileptic attacks, and some of them can keep their symptoms under control by diet and drugs while some others can obtain relief through surgery. Some psychiatrists therefore describe epilepsy as a "disease of the brain", but others classify it as a "disease of the mind". As is no doubt well-known in this province, following the decision of the New Brunswick Court of Appeal in the case of *Marion O'Brien*, the courts tend to regard epilepsy as a "disease of the mind" for the purposes of criminal law.[34]

Some psychiatrists in the United States regard "psychopathy" or "sociopathy" as a disease of the mind, but others do not.[35] In Canada, it is generally classified not as a disease but as a "personality state". Neuroses and personality states are not regarded as "diseases of the mind" in criminal law.[36]

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31 MacNiven, "Psychoses and Criminal Responsibility," in *Mental Abnormality and Crime*, pp. 8-9.

32 See, for example, *Lyles v. U.S.* 254 F. 2d 725, evidence of Dr. Perretti.

33 *Cf., R. v. Charlson*, [1955] 1 All E.R. 859; [1955] 1 W.L.R. 317; 39 Cr. App. R. 37, with *R. v. Kemp*, [1957] 1 Q.B. 399; [1956] 3 All E.R. 249; [1956] 3 W.L.R. 319; 40 Cr. App. R. 121. See Prevezer, "Defence of Automatism", [1958] Crim. L.R. pp. 361, 443.

34 *O'Brien v. R.*, [1966] 3 C.C.C. 288; see also *R. v. Cottle*, [1958] N.Z.L.R. 999; *Bratty v. A.G.N.I.*., [1963] A.C. 386; [1961] 3 All E.R. 523; [1961] 3 W.L.R. 965; 46 Cr. App. R. 1; *R. v. Dirto* (1962), 38 W.W.R. 480; 132 C.C.C. 198; 38 C.R. 32. See Leigh, "Automatism and Insanity" (1962), 5 Crim. L.Q. 160, and Beck, "Voluntary Conduct: Automatism, Insanity and Drunkenness" (1966-7), 9 Crim. L.Q. 315.

35 *Cf.* evidence of Dr. Perretti in *Lyles v. U.S.* 254 F. 2d 725 with that of Dr. Duval, mentioned in *Blocker v. U.S.* (1961), 288 2d 853.

36 See, for example, *8th Annual Report, Forensic Clinic, Toronto Psychiatric Hospital* (1965), Appxs. viii and ix.

Interpretation of Section 16, Criminal Code

The workings of the mind are so inter-related that when a person suffers from a mental disorder it affects all his mental functions. A person who suffers from specific delusions, referred to in section 16(3) of the Code, cannot be medically regarded as "in other respects sane". This subsection therefore refers to a condition which is not recognized in medical science as existing in real life.[37]

The same difficulty confronts many medical men in attempting to relate the condition of any mentally abnormal person to the definition of insanity set out in section 16(2) of the Code. Some, however, manage to express themselves in the language of section 16(2) on the hypothesis that they may with a good conscience describe severely psychotic persons as incapable of appreciating the nature and quality of conduct or of knowing that it is wrong. In Ontario, it seems, they may relate the word "wrong" to a moral as well as to a legal standard,[38] but the Alberta courts appear to follow the English rule by which wrong means illegal and nothing more.[39] The Canadian Royal Commission on Insanity as a Defence to Criminal Charges, in 1956, stated what I have described as the Ontario rule, and also professed to find in the word "appreciate" a greater requirement of understanding than could be extracted from the word "know".[40] I don't think I can say that I "know" the nature and quality of conduct unless I "appreciate" it in the manner defined by the Royal Commission. However, an interpretation similar to that of our Royal Commission was achieved in 1958 by a Committee appointed by the Governor of New York.[41] The New York Criminal Code, recently revised, contains a definition of insanity much like that in section 16 of our Code, with the quali-

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37 There is widespread authority for this statement; see Lindman & McIntyre, *The Mentally Disabled and the Law* (1961), p. 338.

38 *R. v. Laycock*, [1952] O.R. 908; 104 C.C.C. 274; 15 C.R. 292; *R. v. O.* (1959), 3 Crim. L.Q. 151; *Report of Royal Commission on the Law of Insanity as a Defence in Criminal Cases* (Ottawa, 1956), p. 13; this interpretation seems to be correct and will probably be upheld if the issue goes to the Supreme Court of Canada.

39 *R. v. Cardinal* (1953), 10 W.W.R. (N.S.) 403; 17 C.R. 373; *R. v. Wolfson*, [1965] 3 C.C.C. 304; 46 C.R. 8; see *R. v. Windle*, [1952] 2 Q.B. 826; [1952] 2 All E.R. 1; 1 T.L.R. 1344; 36 Cr. App. R. 85. The Australian High Court has disapproved of the English rule in *Stapleton v. The Queen*, [1952] 86 C.L.R. 358.

40 Report of *Royal Commission on the Law of Insanity as a Defence in Criminal Cases* (Ottawa, 1956), at pp. 11-12.

41 *Interim Report of Committee on Criminal Responsibility*, May, 1958, pp. 301-2.

fication that substantial rather than total incapacity is enough for a finding of insanity.[42]

Proposed Substituted Definitions of Insanity

I need not elaborate here the long campaign of attack on and defence of the so-called McNaghten Rules. I will merely mention several proposals for improvement of these rules that have been made.

The majority of the British Royal Commission on Capital Punishment, 1949-53, recommended that the jury should be required to determine whether at the time of the act the accused was suffering from disease of the mind or mental deficiency to such a degree that he ought not to be held criminally responsible.[43]

The minority of that Commission would have continued the McNaghten Rules, with an extension to include cases where the actor is impelled by an "irresistible impulse".[44]

The so-called "Durham" rule, formulated by Judge Bazelon, in the United States Circuit Court of Appeal for the District of Columbia in 1954,[45] asserted that if the unlawful act was the product of mental disease or defect the accused would not be criminally responsible. This test was almost identical with the test adopted in New Hampshire in 1870.[46] One may note by way of irony that whereas the McNaghten Rules were not applied when McNaghten was acquitted, Durham was ultimately found guilty under the Durham Rule.[47]

The American Law Institute's Model Penal Code proposes that a person be not responsible for criminal conduct if at the time of the conduct, as a result of mental disease or defect, he lacks substantial capacity either to appreciate the wrongfulness of his conduct or to conform his conduct to the requirements of law, with a proviso that mental disease or defect does not for the purpose of determining

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42 New York Penal Code, s. 1120, enacted by 1965, c. 593, s. 1, which provides: "A person is not criminally responsible for conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity to know or appreciate either:
(a) The nature and consequence of such conduct; or
(b) That such conduct was wrong."

43 *Royal Commission on Capital Punishment* 1949-1953 Report, para. 790(19); see para. 333.

44 *Ibid.*, Memorandum of dissent, pp. 285-7; see para. 317.

45 *Durham v. U.S.* (1954), 214 F. 2d 862.

46 *State v. Pike* (1870), 49 N.H. 399.

47 On his third trial. His second conviction was set aside: (1956), 237 F. 2d 760.

insanity include an abnormality manifested only by repeated criminal or other anti-social conduct.[48]

This test has been adopted in substance in several circuits of the United States Federal Court System[49] and has been adopted by legislation in Vermont.[50]

Purposes of Criminal Law and Punishment

Before expressing my own views with respect to these rules and proposals, I would like to set out some features of the nature and purpose of criminal law and of punishment as I understand them.

We say that the purpose of criminal law and punishment of offenders is to protect society, but this means very little unless we show what it is against which we seek to be protected by criminal law and punishment, what protection we gain thereby and how this protection is given.

Criminal law and punishment of offenders together constitute an imperfect and inefficient instrument of social control, which embodies that part of the moral standards of our society, that we, acting through the state, have determined to be so vital to the continued existence and well-being of society that its rules and standards must be supported by publicly administered punitive sanctions, including the most severe sanctions which our society is willing to allow the state to impose. The motives that lead to the selection of different kinds of conduct for designation as criminal and the particular sanctions to be employed are diverse, but, no matter for what reasons any particular form of conduct is made criminal or any particular sanction is authorized, there is a moral judgment involved in the characterization of the conduct as so reprehensible that it is defined as a crime and the determination

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48 *Model Penal Code, Official Draft*, 1964, Art. 4.01.

49 *U.S. v. Freeman* (1966), 357 F. 2d 606 (C.A., 2d Circuit). In the District of Columbia, the Durham rule was modified along similar lines in *McDonald v. U.S.* (1962), 312 F. 2d 847. See *Pope v. U.S.* (1967), 372 F. 2d 710 (U.S. 8th Circuit) where a charge on the issue of insanity embracing and requiring positive conclusions by the jury as to defendant's cognition, volition and capacity to control his behaviour, in which elements of knowledge, will and choice were emphasized as essential and critical elements of legal sanity, was held to be legally sufficient. The rules currently accepted in U.S. Circuit courts are summarized in an Appendix to the judgment of Blackmun J. at p. 737: "The U.S. Supreme Court has approved charges embracing *McNaghten* and irresistible impulse.", per Blackmun J. at p. 734.

50 Vt. Stat. Ann. tit. 13, No. 4801 (1959). "Adequate" has been substituted for "substantial" capacity. Congenital and traumatic mental conditions are expressly included in "mental disease or defect."

that anybody who engages in it is an offender and ought to be punished by the state.

From cradle to grave, our moral education is conducted by praise and blame, reward and punishment. We learn to regard as laudable what is praised, particularly if it is rewarded. We learn to regard what is condemned as reprehensible and the more so if it is punished. One function of the criminal law therefore is its contribution to the acceptance by members of society of its generally accepted moral standards through condemnation and punishment of conduct defined as criminal. The moral aspect of criminal law, often expressed in part at least in terms of justice, which is a moral quality, has a bearing on the relation of the criminal law to mental abnormality.

Our criminal law and its administration must be consonant with the general moral sense of the community. Society will not in the long run tolerate and should not tolerate the condemnation as a criminal of a person who is generally regarded as morally innocent, or the condemnation or punishment of a person by a procedure which is generally regarded as morally inacceptable, or the imposition on him of a punishment that is generally regarded as morally unjustifiable. This is a very broad statement and its proper application to individual cases involves many complex moral judgments. What troubles many of us in our efforts to appreciate the relationship between criminal law and morals is that we try too hard to simplify the moral issues involved. We tend to insist that the individual whose harmful conduct is under inquiry and would be criminal in normal circumstances be found either completely wicked and therefore guilty or completely innocent and therefore immune from criminal responsibility. The facts are seldom, if ever, simple enough for such a solution. Moral judgments, if they are to be accurate, must take into account all relevant factors, however complex. Moral guilt is usually relative. This fact should be taken into consideration in our criminal law to a greater degree and more effectively than it is at present.

Our criminal law is founded on the hypothesis that most men are moral beings, capable of making choices based upon a measure of free will, responsible for their conduct and capable of understanding and accepting their responsibility. On the converse of this hypothesis is based the immunity from criminal responsibility of those persons whom we call insane. We consider it immoral and therefore unjust to condemn as criminals those who, by reason of mental defect or disease, cannot be treated as responsible persons. Leaving open for the moment the definition of insanity, I wish to emphasize at this point the moral foundation of immunity on that ground.

Deterministic Theory

This hypothesis is constantly under challenge on the part of exponents of various schools of behavioural determinism, who advance evidence to support the conclusion that the concept of free will is largely if not entirely illusory, that man's attitudes, his decisions and his conduct, are determined by his personality which is the combined product of his inherited qualities and his life experience.[51] Behavioural scientists are able to show how certain events and influences mould personality and can distort it. Defective development of the conscience during childhood, over which the individual has little control, contributes to the making of the psychopath. Individuals with confirmed delinquent personalities have been identified below the age of eight years. Many of the influences having these effects are traced by these scientists back beyond the age at which memory commences. Some of them are found in the family relations of infancy. The attitudes and values of the individual are influenced by those of the group to which he belongs or of his "reference group", which means the group by whose standards he judges himself and others, whether or not he belongs to it. All education, particularly moral education, and all criminal and penal legislation and its administration, are based on the assumption that conduct can be determined. Our general theories of society are founded on this assumption.

From this evidence, several schools of criminologists have concluded that it is unreal and impractical to found criminal law and its administration on any theory of responsibility.[52] It is argued that the sole purpose of criminal law is to prevent future socially harmful conduct, and this can be done best by avoiding moral judgments and by seeking simply to change attitudes and mould personalities through various forms of psychological and psychotherapeutic treatment of offenders, and through welfare and educational measures in society generally. One of the recent exponents of this theory is Lady Barbara Wootton, a prominent English sociologist, who set out her thoughts briefly in a series of lectures delivered under the Hamlyn Trust and published in 1963 under the title "Crime and the Criminal Law".[53] Her conclusion, like that of others of this school, is that there are only two questions,

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51 All positivistic theory is, to the extent that it is consistent, based on this hypothesis.

52 "To found an institution, as eminently empirical and practical as a penal system should be, on a metaphysical soapbubble like the freedom of the will (imputability) can obviously no longer be done when once it is discovered that the fundamental conception is not of this world.": Olof Kinberg, *Basic Problems of Criminology* (1935), p. 57.

53 Hamlyn Lecture Series, No. 15.

namely, did the accused person commit the act or omission charged, and, if so, how is he to be treated in order to mould his personality and attitudes in order to ensure, as far as possible, that he will not do so again.[54] The concept of responsibility is to be eliminated and conversely the concepts of immunity from responsibility and diminished responsibility on the ground of mental abnormality are to be discarded.[55]

On the face of it, there is a great deal of evidence to support this type of approach to criminal law and its enforcement. The effort to brush aside this type of attack on our traditional attitudes towards criminal law simply by saying that the law is concerned with responsibility and not with medical or psychological problems illustrates a refusal to deal adequately with the problems involved. It requires us to try to ignore the fact that the investigations of the deterministic schools have created a body of knowledge concerning the nature and causation of criminality which simply cannot be ignored by reasonable men.

Necessity of Concept of Responsibility

On the other hand, there is a paradox inherent in all deterministic theories, namely, that the healthy development of the personality requires a well-developed conscience, and the existence of this conscience in an individual and its full and healthy development require him to believe that he has the capacity to make moral judgments and to make moral decisions.[56] In other words, whether or not his choices and his decisions and his conduct are predetermined, he must, in order to become a healthy, fully-developed person, believe that he can exercise free will and that he ought to make decisions based on moral judgments. Even if this belief is false, it appears to be necessary that it be held by the ordinary person with well-developed personality. Development of this belief seems to be essential also for successful psychotherapy in relation to mentally abnormal persons, who cannot be brought into a state of full mental health unless they can grasp and feel subjective responsibility for their own decisions and their own conduct.[57] This may seem to involve what might be called the "big lie"[58] but

54 *Ibid.*, pp. 32-57, 91-118.

55 *Ibid.*, pp. 58-84.

56 Lewy, *Responsibility, Free Will and Ego Psychology* (1961), 42 Int. J. of Psychoanalysis, 267-8. Mower, *Guilt in the Social Sciences*, in *Psychiatry and Responsibility* (1962), pp. 38-67.

57 Katz, "Responsibility and Freedom" (1953), 5 Journal of Legal Education, 274-5.

58 See Halper, "Existential Responsibility and Psychotherapy" (1965), *Issues in Criminology* (U. of Cal., Berkeley) 52, at p. 65.

it seems rather to require rejection of the principle of absolute determinism and acceptance of a measure of choice and a degree of free will for most men.

Criticisms and Proposal

It seems to follow that the generally held belief that some, at least, mentally abnormal persons should be held criminally responsible for their conduct is well founded. In many cases, a judgment that he is not responsible is harmful to the actor. It would seem to follow that the only persons who should not be criminally responsible are those whose mental abnormality is so great that they cannot grasp any substantial sense of responsibility with reference to objective reality. If this conclusion is correct, we must, I think, reject the Durham Rule, since it would be wrong to exclude from criminal responsibility every person whose conduct is the product of mental disease or defect. This rejection would render irrelevant many severe criticisms of the Durham Rule based on the inability to identify causation and consequence in the relationship between mental disease or defect, on the one hand, and conduct on the other,[59] since we simply could not accept the Durham Rule and at the same time assert that some mentally ill or mentally defective person should be criminally responsible.

Ideally, the rule recommended by the majority of the British Royal Commission on Capital Punishment sets out the purpose of any rule which is to define immunity on the ground of insanity, namely, to determine whether the actor is so mentally disordered that it would be unjust to hold him criminally responsible.[60] However, the proposition seems to be too vague and indefinite for guidance of judges and juries in dealing with individuals.

The McNaghten Rules as originally stated, and even section 16 of our Criminal Code, suffer from two defects. In the first place, the test is purely intellectual, and we have learned that you cannot isolate the intellectual aspect of mental disorder. In the second place, the rule is stated in an absolute form. It fails to take into account that there are persons who are capable of expressing in some fashion and, perhaps, in a very limited way, understanding the nature and quality of conduct or asserting in a kind of abstract form knowledge of the wrongfulness of conduct, but are so deeply defective mentally or are so seriously disordered that they are incapable of making

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59 For criticisms, see Lindman & McIntyre, *The Mentally Disabled and the Law* (1961), pp. 341-3; see also, *Blocker v. U.S.* (1961), 288 F. 2d 853, per Burger J.

60 *Royal Commission on Capital Punishment* 1949-1953 Report, para. 790(19); see para. 333.

choices and decisions and exercising control over their conduct in accordance with this understanding.[61] The effort of the minority of the English Royal Commission, 1949-53, to overcome these problems by adding to the McNaghten Rules the exemption of those who act under the compulsion of an irresistible impulse is in line with many proposals of a similar nature made during the past century. Many psychiatrists, however, say they cannot determine whether an impulse is irresistible or whether it has not been resisted. Others might argue that the fact that it has not been resisted proves that it was irresistible. These difficulties make the proposed rule difficult to employ.[62]

On balance, it seems to me that the best proposal is that of the American Law Institute.

This test is not perfect. In respect of the issue of inability to conform one's conduct to the requirements of the law, it suffers to a degree from the same defect as the "irresistible impulse" test, namely that one can never be quite sure whether the supposed inability to conform is merely failure to conform. The exclusion from the definition of mental disease or defect of abnormality manifested only by repeated criminal or otherwise anti-social conduct is intended to guard against undue extension of immunity in this direction. The first part of the proposed rule is related to intellectual capacity to appreciate, but the word "substantial" is intended to ensure that minimal capacity will not support criminal responsibility if there is substantial incapacity, and to recognize that deep emotional disorder may substantially impair overall capacity even though rudimentary intellectual capacity seems to be present.[63]

For these reasons, my colleague, Professor Stanley Beck, and I, on being invited to express opinions before the House of Commons Standing Committee on Justice and Legal Affairs on November 29th last, expressed a preference for the American Law Institute Rule over either the present rule or the Durham Rule.[64] Andrew Brewin, Q.C., M.P., had introduced a bill which would substitute the Durham Rule for the present section 16, but when we stated our preference he indicated that he would not oppose the adoption of the American Law Institute Rule.[65]

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61 For criticisms of these rules, see Lindman & McIntyre, *The Mentally Disabled and the Law* (1961), pp. 336-9.

62 For criticisms, see *ibid.*, pp. 339-41.

63 For criticisms, see *ibid.*, pp. 343-5.

64 *House of Commons Standing Committee on Justice and Legal Affairs, Minutes of Proceedings and Evidence*, No. 19, November 29, 1966, pp. 657-672, 688-704. (Bill C-105).

65 *Ibid.*, p. 655.

However, both Professor Beck and I stressed before the Committee and I would emphasize here that, while it is necessary in accordance with our view of the proper scope of criminal law to have a rule asserting immunity from criminal responsibility on the ground of severe mental abnormality, defined as we have recommended, only a very small minority of mentally abnormal persons *should* be immune from criminal responsibility and *would* be immune under any of the rules under consideration.

The Committee, I may say, rejected both Mr. Brewin's proposal and ours, but recommended that in section 16 the phrase "disease of the mind" be replaced by "disorder of the mind".[66]

Infrequency of Insanity Plea

One occasionally hears it said that in the District Columbia the number of acquittals on the ground of insanity has been reduced following the adoption of the Durham Rule. This information is not consistent with the statistics available to me, which indicate that during the years 1952 to 1954, in the District of Columbia, .30 per cent of persons found to have committed otherwise criminal acts were found not guilty by reason of insanity, while in the five years following adoption of the rule the percentage rose to 1.3 per cent.[67] By way of comparison, the number of persons acquitted on the ground of insanity and detained as unfit to stand trial because of insanity in Canada, during the years 1960 to 1964 inclusive, taken together, amounted in all to less than .07 per cent of those otherwise found to have committed indictable offences.[68] The small number of such persons so found in Canada reflects in part the Canadian attitude towards acquittal on the ground of insanity. The plea of not guilty by reason of insanity is seldom made except in defence to a capital charge, and when it is successful the person is usually treated as if he had "cheated the gallows". He is generally regarded as having been convicted, and there is a decision of an Ontario court to the effect that he is in the same position in relation to escape or rescue as a person serving a term of imprisonment.[69] The general policy of provincial governments has seemed to be based on the belief that he is a wicked person and should have been hanged and he cannot complain if he is incarcerated for the

66 *Ibid.*, No. 27, 8th Report, February 28, 1967, pp. 950-1.

67 See Clayton, "Durham Rule Weighed after 5 Years in Use", quoted in Donnelly, Goldstein & Schwartz, *Criminal Law*, (1962). In Wily and Stallworthy, *Mental Abnormality and the Law* (1961), at p. 386, it is said that, apparently up to the end of 1960, out of 10,000 defendants charged in the District of Columbia since 1954, 90 had succeeded in an insanity plea, which would represent an average of .9%.

68 *Statistics of Criminal Other Offences*, D.B.S., annual reports 1960-4.

69 *R. v. Trapnel* (1910), 22 O.L.R. 219; 17 C.C.C. 346; 22 D.L.R. 219.

rest of his life.[70] Many of us share that belief. It is little wonder that persons charged with other than capital offences and their counsel hesitate to plead not guilty by reason of insanity in answer to a non-capital charge although the finding is equally applicable to any criminal charge. Canadian practice requires us to believe that insanity as related to immunity is to be regarded as a defence and to be introduced in issue by the defendant, if at all,[71] although,

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70 For example, in *R. v. Coleman* (1927), 47 C.C.C. 148, the accused was found not guilty by reason of insanity and was detained by order of the Lieutenant-Governor in Halifax Jail, which nobody in his wildest dreams ever thought of describing as a therapeutic institution. It is reported privately on good authority that in one province on one occasion an accused found "not guilty of murder by reason of insanity" was discovered on admission to a mental hospital not to be "insane" or "mentally ill". He had "put it across" the jury. The Lieutenant-Governor refused to release him, and as far as I could learn he is still in custody. See also Swadron, *Detention of the Mentally Disordered* (1964), pp. 379-382. As Swadron mentions at pp. 386-7, procedures for release of persons so detained have been set up in Saskatchewan, Alberta and Ontario. Only in Saskatchewan is the procedure statutory and it has apparently disappointed the psychiatrists. The *ad hoc* arrangement in Ontario has released a few pathetic persons, one of whom had been in custody for 42 years and had apparently not been "insane" for a considerable number of years before his release, if at all. The Board of Review provided for Ontario Mental Hospital patients by (1966), 15 Eliz. II, c. 88, s. 1, does not yet apply to these detainees. A new Mental Hospital Act which will provide relief for them is promised but not in sight at the time of writing. As it is now, no patient can ask for review as of right anywhere in Canada. It was said by Dr. Rhodes Chalke in a public lecture on May 1, 1967, that in a recent survey he had found several persons, acquitted by reason of insanity, kept in provincial jails because provincial authorities refused to admit them to mental hospitals; one, acquitted on that ground by Court Martial, is kept in Stony Mountain Penitentiary, because no Manitoba provincial institution will receive him, notwithstanding protests from the Commissioner of Penitentiaries.

71 Except for an oblique reference in *R. v. Keirstead* (1918), 42 D.L.R. 193, I have found no Canadian authority on this point. In answer to written inquiries directed to Attorney-General's Departments and the Department of Justice in 1960, the replies I received were unanimous in stating the propositions herein set out. It is significant that both the *Canadian Royal Commission on the Law of Insanity as a Defence in Criminal Cases* (1956), and Arthur Martin, "Insanity as a Defence" (1965-6), 8 Crim. L.Q. 240, refer to insanity as a "defence". In England, Donovan J. held in *R. v. Bastian*, [1958] 1 All E.R. 568*n*; [1958] 1 W.L.R. 413; [1958] Crim. L.R. 391; 42 Cr. App. R. 75, that the Crown could raise the issue, but Lawton J. held in *R. v. Price*, [1962] 3 All E.R. 957; [1962] 3 W.L.R. 1308; [1963] 47 Crim. App. R. 21, that only the defence could do so. See comments by Samuels, [1960] Crim. L.R. 453, approving of *Bastian*, and Macaulay, [1963] Crim. L.R. 817, approving of *Price*. Lord Denning, in *Bratty v. A.G.N.I.*, [1963] A.C. 386, approved of *Bastian*, but got no support from the other Law Lords. It would seem to be illogical for the prosecution to seek a verdict of "not guilty" by reason of insanity, but we swallow many more illogical rules and practices.

where the issue is unfitness to stand trial, either the Crown or the accused may raise the question. There is an exception to this rule with respect to the "defence of insanity". Under recent decisions, such as *Marion O'Brien's* case,[72] if the accused relies on automatism and the cause of the automatic conduct is related to epilepsy or a disease of the brain, the judge is required to put only the issue of insanity to the jury whether the accused wishes it to be done or not, and not to allow them to decide on the question of automatism unless there is evidence that there may also have been some other cause of the automatic conduct. Such cases, although spectacular, are not common. The Crown should be responsible for raising the issue of insanity or other mental abnormality in all appropriate cases. If neither party does so, the court should. Moreover, the accused should have a right to appeal from a finding on this issue. At present, the accused cannot appeal against an acquittal on the ground of insanity.[73]

Incidence of Mental Abnormality Among Offenders

Even if the Durham Rule were adopted, with the consequences that seem to have followed in the District of Columbia, at least 98.7 per cent of persons found to have committed otherwise criminal acts would be criminally responsible. Nobody would deny that more than 1.3 per cent of offenders are mentally abnormal. The great majority consists of persons who are in the broad area of normality. Even the person of confirmed delinquent personality is normal within our accepted understanding of the term. Moreover, I do not assert that all mentally abnormal persons are mentally ill. Nevertheless, a substantial number of offenders are mentally abnormal and of this group a considerable number are mentally ill. Statistics in this area are lacking, but from information that I have gained concerning the population of penitentiaries in the Ontario region, it appears that more than 15 per cent of penitentiary inmates are in need of some form of psychiatric treatment. These are persons whose abnormality ranges from moderate to severe and they include a group which may amount to 4 per cent or more of the inmate population whose members are certifiable as mentally ill. Some of this last mentioned group are actually kept in provincial mental hospitals under treatment during the time required, in the judgment

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72 [1966] 3 C.C.C. 288; see also footnote 34.

73 See comments by Swadron, *Detention of the Mentally Disordered* (1964), pp. 367-376.

of the hospital staff, for treatment. The remainder are kept in maximum security penitentiaries in what are euphemistically called psychiatric wards, or else in solitary confinement in what inmates graphically call "the hole".[74]

If one may judge from statistics published by the Ontario Department of Health, perhaps 900 to 1,000 persons who came before the criminal courts in Canada in 1963 and who either had or might have committed otherwise criminal acts were mentally ill to such an extent as to be certifiable under provincial legislation, which requires that the patient be not only mentally ill but also in a condition which requires his being kept in custody for his own protection or that of others.[75] They suggest also that a number of other accused persons, perhaps 4,000 to 4,500 of them, were sufficiently mentally abnormal that they were or should have been referred to psychiatrists for diagnosis and a considerable number of those would require psychiatric treatment.

I think that I can say categorically that our maximum and medium security penitentiaries and most provincial penal institutions rank high in unsuitability for treatment of most inmates

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74 This information has been gained largely through personal contact with members of penitentiary staffs and some contact with inmates over the past nine years. Some idea of the nature and extent of the problem can be gained from the evidence of Drs. George D. Scott and R. J. McCaldon, Penitentiary Staff Psychiatrists in the Ontario region, in *Proceedings of the Special Joint Parliamentary Committee on Penitentiaries*, No. 4, Feb. 2, 1967, pp. 148-73, and No. 8, March 3, 1967, pp. 299-315. In the *Report of the Commissioner of Penitentiaries* for the Year ending March 31, 1965, p. 29, it was said that about a third of inmates made use of psychiatric services; before staff psychiatrists were appointed 1 in 17 inmates would be committed to provincial institutions but the ratio had been reduced to 1 in 80. From the doctors' evidence it appears that a considerable number of inmate interviews with psychiatrists are part of the endless effort towards "manipulation of staff" constantly exerted by many inmates. Not all the one-third of inmates reported by the Commissioner are necessarily mentally disordered. I am informed that on May 1, 1967, there was in Kingston Penitentiary 179 inmates diagnosed as psychotics; the "psychiatric ward" houses about 45 of them.

75 *Report of Mental Health Branch*, Table 17. — Admissions: Sec. 35, Mental Hospitals Act, R.S.O., 1960, c. 236 by Lt. Governor's Warrant, 66: Sec. 38, order of Magistrate, 762, of which 235 certificated, 4 remained as voluntary patients; in all 828, of whom 305 certifiable. In 1965, 189 patients were referred to Forensic Clinic, Toronto Psychiatric Hospital by courts and probation officers. In 1964, 808 patients were referred to other outpatient clinics by courts, probation officers and police.

who require psychiatric treatment, whether they are certifiable or not.[76]

At this point, I return to my proposition that, although a considerable number of mentally abnormal and even mentally ill persons ought to be found criminally responsible for conduct otherwise criminal, we ought to realize that moral and therefore criminal responsibility can be relative. Moral and criminal judgments should take into account the mental abnormality of the actor whose conduct is being judged. We have no justification for saying that the mentally ill person is mentally ill because he wishes to be or even that the psychopath is what he is from choice. Gradations in responsibility should be reflected in punishment, which should be selected and administered, as far as possible, with a view to ensuring that the offender will not offend again, and that if, by reason of his tendencies, he poses a serious threat to society he should be kept in custody or under control while being treated in such a matter as to overcome his criminal proclivities. Prolonged custody can be justified only for that reason.

English Mental Health Act, 1959, and Scottish Counterpart

These considerations lead me to suggest that we could in Canada gain by following the examples of England and Scotland, as set out in the English Mental Health Act, 1959,[77] and similar legislation of the following year applicable to Scotland.[78]

Under this legislation, where a person is convicted of an offence punishable with imprisonment, where the punishment is not fixed by law, and the court is satisfied on the written or oral evidence

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76 See evidence of Drs. Scott and McCaldon, in *Proceedings of the Special Joint Parliamentary Committee on Penitentiaries*, No. 4, Feb. 2, 1967, pp. 299-315, particularly Dr. Scott, at pp. 153-4, and Dr. McCaldon at pp. 300-1; see also O'Connor, "Impressions Concerning Adaptation to Imprisonment," *in Proceedings, Canadian Congress of Corrections*, 1957, 110, and Cormier, "The Psychological Effects of the Deprivation of Liberty on the Offender," *ibid.*; 137. Fornataro, *Canadian Prisons To-day*, in *Crime and its Treatment in Canada* (1965), pp. 316, 321. Private communications from Dr. Barry Boyd, Superintendent, Ontario Hospital, Penetanguishene, tend to confirm this proposition. For example, in Ontario, male sexual deviates and narcotic addicts are confined in a shiny but oppressive super-maximum security prison along with the hostile-aggressive inmates for whom the prison was designed.

77 7 & 8 Eliz. II, c. 72, Part V, ss. 60-71, particularly ss. 60-1, 65.

78 *Criminal Justice (Scotland) Act, 1960*, 8 & 9 Eliz. II, c. 61.

of two medical practitioners that the offender is suffering from mental illness or psychopathic disorder or mental defect, and that the mental disorder warrants the detention of the patient in a mental hospital for medical treatment or out-patient treatment under supervision, and the court is of the opinion, having regard to all the circumstances including the nature of the offence and the character and history of the offender, and to the other available methods of dealing with him, that the most suitable method of disposing of the case is by such treatment, the court may authorize the detention of the offender for treatment in a mental hospital or place him under the guardianship of a local health authority or approved person for outpatient treatment. Such an order for admission to a mental hospital is not to be made unless arrangements have been made for the admission of the offender to that hospital within a short time and no order for guardianship is to be made unless the local health authority or person named is willing to receive the offender into guardianship. When such an order is made, no fine and no term of imprisonment may be added, but any other order which the court may make may also be made. Somewhat similar powers are given to courts dealing with children and young persons. Where the offence is summary a hospital or guardianship order may be made without conviction. In making the hospital order, the court may, if it appears desirable, impose restrictions on the release of the offender either indefinitely or for a fixed time. Subject to such an order, the period of treatment is indeterminate. The time of discharge from hospital is determined primarily by the staff of the hospital, but the patient may apply from year to year for his release to a board called The Mental Health Review Tribunal. Where restrictions on discharge have been imposed by the court, they may be removed by the Secretary of State who may authorize discharge conditionally or absolutely. Under another statute,[79] courts are authorized to impose a condition of probation that the offender submit for a period not exceeding twelve months to appropriate treatment, in or out of hospital, for mental disorder. Power to transfer inmates of prisons to hospitals and to detain during pleasure of the Crown persons found unfit to stand trial or not guilty by reason of insanity is continued.

Studies of the working of this legislation up to the end of 1962 have been published, and they suggest that it is working very well.[80]

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79 *Criminal Justice Act, 1948*, 11 & 12 Geo. VI, c. 58, ss. 3 & 4.

80 McCabe, Rollin and Walker, "The Offender and the Mental Health Act" (1964), 4 *Medicine, Science and the Law, 231.*

In 1962, 2,171 persons found to be mentally abnormal were disposed of as follows:[81]

Transferred from prison to hospitals before trial and sentence	5
Placed on probation with requirement of outpatient treatment	380
Placed on probation with requirement of inpatient treatment	456
Placed on guardianship under the Mental Health Act	14
Subjected to hospital order without conviction (summary offence)	52
Placed under hospital order after conviction without restriction order	892
Placed on similar order with restriction	136
Found insane and unfit to stand trial	36
Found guilty but insane (now not guilty by reason of insanity)	9
Found of diminished responsibility under the Homicide Act 1957, (a verdict available only on a charge of murder and resulting in a conviction of manslaughter)	34
Found guilty of infanticide	17
Transferred from prison to hospital during sentence	140
TOTAL	2,171

The courts regard their discretion as important and in a number of cases have refused to make hospital orders because they are not satisfied with the degree of security in the regime of the hospitals concerned, or for some other reason.[82]

The British system seems to be superior to our own, since a remand for observation under section 451(c) or 524(1a) or 710(5) of the Criminal Code does not dispose of the charge if the accused is certified and retained in the institution and, as we have seen in the *Fawcett* case,[83] either injustice or an appearance of injustice may result. The accused may have the charge hanging over his head for the rest of his life, and it may never be determined whether he in fact committed the act or omission which was the cause of

81 *Ibid.*, p. 235.

82 Walker, "The Mentally Abnormal Offender in the English Penal System" (1965), The Sociological Review, Monograph, No. 9, Sociological Studies in the British Penal Services, 133; Thomas "Sentencing the Mentally Disturbed Offender", [1965] Crim. L.R. 685.

83 *Fawcett v. Attorney-General of Ontario*, [1964] S.C.R. 625; [1965] 2 C.C.C. 262; 45 D.L.R. (2d) 579; 44 C.R. 201.

his being brought before the court. Moreover, if the accused is returned to the court from such a remand, the court, as in the case of *Robin Roberts*,[84] is not always informed fully of his condition, although it may be very important when the time for sentencing comes around that a full report be available. A number of psychiatrists have said that they fear to submit a full report on return of the accused before trial since the information it contains may apparently involve a confession of guilt.[85] Finally, if the accused is not certifiable under provincial legislation and is not suitable for probation, our present law seems to offer no alternative to ordinary imprisonment which may be quite inappropriate.

Possible Application in Canadian Penal System

The scheme of the Mental Health Act seems preferable to the introduction of the Scottish and English defence of diminished responsibility,[86] since that defence is specifically confined, in England at any rate, to a charge of murder and, as the Canadian Royal Commission on Insanity observed in 1956,[87] the result is merely the substitution of a conviction for manslaughter instead of one for murder, and the accused would under our present law be sentenced to imprisonment in the ordinary way. In Canada, such an accused would probably not be convicted of capital murder, if his mental condition justified a finding of diminished responsibility, so that the only result would be that, instead of a mandatory life imprisonment for non-capital murder, he would be subject to a term of imprisonment fixed by the court which might be for life. Treatment in therapeutic institutions would appear to be most appropriate for many such offenders. Under the scheme of the English Mental Health Act, the court may recognize diminished responsibility in any case, and, where it seems appropriate, substitute an indeterminate period of treatment either in or out of custody for a period of imprisonment.[88] The discretion given to

84 *R. v. Roberts*, [1963] 1 O.R. 280; [1963] C.C.C. 27; 36 D.L.R. (2d) 696; 39 C.R. 1.

85 See evidence of Dr. Barry Boyd, *House of Commons Committee on Justice and Legal Matters, Minutes of Proceedings and Evidence*, No. 9, July 7, 199, pp. 234-5 (Bill C-176).

86 This defence, reducing murder to culpable homicide (manslaughter), was introduced into Scots law by judicial creation, *H.M. Advocate v. Dingwall* (1867), 5 Irv. 466, and into English Law by the *Homicide Act*, 1957, 5-6 Eliz. II, c. 11, s. 2.

87 *Report of the Royal Commission on the Law of Insanity as a Defence in Criminal Cases*, pp. 66-7.

88 See McCabe, Rollin and Walker, "The Offender and the Mental Health Act" (1964), 4 Medicine, Science and the Law, 231, at pp. 236-7; and Thomas, "Sentencing the Mentally Disturbed Offender", [1965] Crim. L.R. 685, at p. 686, *n* 1.

the court is important, since some mentally abnormal persons will respond about as well to treatment in prison as to treatment in a mental hospital. Others should be confined in a mental hospital for treatment, while still others can be treated out of custody. It seems preferable, where it can be determined that psychotherapy in a therepeutic institution is indicated, to provide for such treatment of an offender in the sentence, rather than to commit the offender for a term to a penal institution. In the first place, the regime at a penal institution is basically and intentionally degrading, and degradation is likely to be more harmful than beneficial to the inmate and to hinder his cure if he is mentally abnormal. Secondly, the atmosphere in a penal institution tends to be one of hostility, that is to say, "we", the inmate population, tend to be at war with "they", the administration and all those related to it.[89] In the third place, in maximum and even medium security penal institutions, considerations of custody and administration come first, and considerations of treatment lag far behind. Even in minimum security institutions, treatment does not receive first priority. Finally, the offender sentenced to imprisonment is usually sentenced to a term which has no relation to the period of treatment required. If removed from prison to a mental hospital for treatment, then, on completion of treatment, he may come back to the penal institution to complete a term which is no longer necessary for him, and which may undo whatever good has been done by the psychotherapeutic treatment. Mentally disordered prisoners often improve greatly in condition on being transferred even to maximum security mental hospitals but regress severely on being sent back to prison.

Fear of undue haste by hospital authorities in releasing a dangerous offender may be overcome by a restriction on release imposed by the judge as part of the sentence.[90]

I do not wish to be thought of as a Pollyanna. I am well aware that the recognition of a mental abnormality is far easier than the determination of its cause, and that diagnosis is far easier than cure. Some forms of mental abnormality cannot be treated in the present state of medical science and in these cases there is no course open except segregation in custody. This is particularly true where the cause is degenerative change of an organic nature. Psychopathy, in many manifestations, is highly resistant to treatment of any

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89 See evidence of Dr. Scott in *Proceedings of the Special Joint Committee on Penitentiaries*, No. 4, Feb. 2, 1967, pp. 148-73, and Fornataro, "Canadian Prisons To-day" in *Crime and Its Treatment in Canada* (1965), pp. 306-7.

90 *Mental Health Act*, 1959, 7 & 8 Eliz. II, c. 72, s. 65.

kind.[91] Apparent cures of mental disorder are often only conditional and relapses are frequent. Admitting all these adverse factors, I think that the balance is still in favour of psychotherapeutic treatment where it is indicated as preferable on diagnosis.

How would this reform be carried out? In Canada, mental hospitals are now entirely within provincial jurisdiction,[92] while penal institutions are divided between national and provincial administration.[93] Probation is exclusively a provincial affair.[94] However, the criminal law is within the national legislative jurisdiction and the power of Parliament to enact criminal law undoubtedly includes power to prescribe procedure and sanctions in the widest sense.[95] Clearly Parliament can enact a provision for sentencing similar to that in the English Mental Health Act, 1959. The problem is by whom and where facilities for treatment ought to be provided.

At the present time, a measure of psychiatric treatment is provided in all penal institutions. In testifying recently before the Senate-House special Joint Committee on Penitentiaries, Dr. George D. Scott, of Kingston, the staff psychiatrist for the Ontario Region of the Penitentiary Service, commented on the inadequacy of existing facilities in that region. Even taking into account available maximum security space in the Ontario Hospital system, the needs of difficult cases cannot be provided for, and the accommodation at Kingston Penitentiary is inadequate and unsatisfactory. Only the inmates of the Prison for Women seem to receive adequate attention in his opinion.[96] As one having some slight familiarity with that institution I may express serious doubt whether even they are adequately provided for. I am informed that conditions are no better in other regions of the penitentiary system.

Provision is being made for construction of medico-psychiatric units in each penitentiary region.[97] These centres are to be welcomed.

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91 Wily and Stallworthy, *Mental Abnormality and the Law* (1961), p. 195; but see p. 192 where it is said that there is a strong tendency for psychopaths to mellow with the passage of time.

92 *British North America Act*, 1867, 30 & 31 Vict., c. 3, s. 92(7).

93 *Ibid.*, ss. 91(28) "penitentiaries", 92(6) "public and reformatory prisons".

94 There is no constitutional reason why a national probation service could not be created.

95 See *Johnson v. A.G. Alta.*, [1954] S.C.R. 127; [1954] 2 D.L.R. (2d) 625; 108 C.C.C. 1; 18 C.R. 21, and *R. v. Superior Publishers et al.*, [1954] O.R. 981; 110 C.C.C. 115; 20 C.R. 51; *R. v. Neil* (1957), 119 C.C.C. 1, 11 D.L.R. (2d) 545; 26 C.R. 281.

96 See footnote 74. Drs. Scott and McCaldon deserve great credit for their work and no doubt other staff psychiatrists are equally devoted.

97 *Special Joint Parliamentary Committee on Penitentiaries, Proceedings*, Evidence of A. J. MacLeod, Commissioner of Penitentiaries, No. 2, January 24, 1967, 49.

It is to be hoped that they will be given priority over the proposed new maximum and super-maximum bastilles now planned and that their introduction will be accompanied by increases in therapeutic staffs. However, as in all professional fields, there are shortages of qualified personnel. Salaries and conditions of work must be improved if professional and sub-professional staffs are to be enlisted in adequate numbers. In my opinion these institutions will not solve the problems I have outlined, although they will ameliorate conditions in penitentiaries.

Basically, the situation is similar in most provincial institutions.

My suggestion is that agreements be made between the national and provincial governments to provide for accommodation and treatment, both as inpatients in mental hospitals and clinics and as outpatients, of those offenders who are found by the courts to be appropriate subjects for orders under an equivalent of the Mental Health Act, 1959. These steps will take time, because institutions cannot be built overnight, but they can be built more quickly than staffs can be trained. Recent trends towards increased outpatient treatment of mentally abnormal persons should help to reduce overcrowding in provincial mental hospitals. I would suggest that aggressive measures be taken, at both levels, national and provincial, with a view to making adequate provision for these cases.

Possible Implications

Such a step would create several major problems of principle. The first, is whether insanity as a defence to criminal charges should be eliminated. It has been urged by some British thinkers[98] that this defence is, if not obsolete, at least obsolescent there. Only 9 persons were found not guilty by reason of insanity in England in 1962.[99] If I am correct, recognition of the principle of responsibility requires us to retain the defence, although it may not be often raised.

A similar problem arises with regard to capacity to stand trial. It would seem to be desirable to have in every case a judicial determination whether the accused person was a party to the conduct which is alleged to have been criminal. The rule preventing trial of such persons was developed when they could not have counsel or any assistance at trial and no witnesses could be called on their behalf. The issue whether the accused did the act can now be tried where it is alleged that the accused is not guilty by reason of insanity.

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98 Barbara Wootton, Hamlyn Lecture Series, No. 15; Nigel Walker, *Crime and Punishment in Britain* (1964), p. 293.

99 McCabe, Rollins and Walker, "The Offender and the Mental Health Act" (1964), 4 Medicine, Science and the Law, 231.

It seems possible to try it even though the accused is incapable of appreciating the nature of the charge and of the proceedings, since he can now be represented by counsel who may be given complete facilities for preparation and conduct of the defence, except insofar as the accused is incapable of instructing him.[100] Moreover, if the *Podola* case[101] is correctly decided, or if we consider it proper to try persons who are suffering from complete amnesia, arising from any cause, with relation to the time of the conduct in question, there does not seem to be any difficulty in having the issue of commission of the alleged conduct tried even though the accused is incapable of understanding what it is all about. If so, the accused may be found not guilty if he did not do the act, or, if he did, not guilty by reason of insanity or he may be made the subject of an order under the equivalent of the English Mental Health Act, 1959. If I am correct, the issue of fitness to stand trial, should not arise. The House of Commons Committee on the Administration of Justice has recommended that introduction of the issue of fitness to stand trial might be postponed until after completion of the case for the Crown, and that if no case were made out the accused could be simply acquitted.[102] Although an improvement over the present arrangement, this proposal seems inferior to my own.

The third question relates to the issue of automatism. Under the doctrine of the *O'Brien* case,[103] if the defence is automatism, and if the cause of the automatism is apparently either disease of the mind or disease of the brain, the issue must be one of insanity, whereas if the cause of the automatism is apparently injury or a drug or somnambulism, and so on, the issue is simply one of voluntary conduct or no voluntary conduct. If there is no voluntary conduct the accused is simply acquitted. Logically, the issue should be the same in each case, since if the conduct is automatic there can be no voluntary conduct which can be the subject of insane volition, whether the automatism is caused by disease or organic condition or any other cause, but pragmatically there is some justification for the *O'Brien* type of decision, provided that a finding of not guilty by reason of insanity is not necessarily followed by

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100 See evidence of Dr. Boyd, *House of Commons Committee on Justice and Legal Matters, Minutes of Proceedings and Evidence*, No. 9, July 7, 1966, pp. 234-5 (Bill C-176), and discussion by Swadron, *Detention of the Mentally Disordered* (1964), pp. 322-5.

101 *R. v. Podola*, [1960] 1 Q.B. 325; [1959] 3 All E.R. 418; [1959] 3 W.L.R. 718; 43 Cr. App. R. 220.

102 *House of Commons Standing Committee on Justice and Legal Affairs, Minutes of Proceedings and Evidence*, No. 27, 8th Report, February 28, 1967, pp. 949-50.

103 [1966] 3 C.C.C. 288.

incarceration for life or an unduly prolonged time in a maximum security mental hospital.[104] It seems unjust that an epileptic who may be capable of living a useful and valuable life in society under a controlled regime, and subject to supervision, if necessary, should be incarcerated either in a mental hospital or in a prison. What we need is some rational disposition of the case following the finding. It might be feasible to combine several recent proposals and to authorize a verdict of not guilty by reason of automatism coupled with provision for treatment. The employment of probation orders without conviction has been discussed, and this might be a good case for their use. The proper disposition of a case of automatism should be casuistic. We should not allow ourselves to become enmeshed, as we have been, in analytical entanglements, arising from exercises in arid semanticism, and for that reason to ignore pragmatic considerations. Some cases of automatism should as I have suggested, involve orders under the equivalent of the Mental Health Act, 1959. Others, where recklessness seems to be involved, might require some punishment to teach a lesson, since for example, a person who knows that he is epileptic and deliberately drives a motor vehicle while not complying with an appropriate regime, and who suffers an epileptic seizure and causes harm in consequence, should be treated as a responsible person and punished to the extent necessary to warn him that he must not do so again.[105] On the other hand, the victim of advanced arteriosclerosis or senile dementia could be the subject of a Mental Health Act type of order, or if sufficiently deranged, could be found not guilty by reason of insanity and detained under section 526 of the Code.

The application of the Mental Health Act type of order to alcoholics or drug addicts, could be worked out without too much difficulty. Our present treatment of addicts of both classes is generally unsatisfactory. Many of these persons can and should be dealt with outside the criminal process, but the proceedings I recommend would be applicable when criminality other than addiction is involved. The court would have to use its discretion in determining whether a Mental Health Act type of order was appropriate to the individual case.

One factor to be taken into account would be the increased need of diagnostic facilities for the efficient administration of a law of this kind. Another would be the necessity for establishment of additional outpatient clinics or improved qualification of general

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104 See Edwards, *Automatism and Social Defence* (1965-6), 8 Crim. L.Q. 258, at pp. 285-9, and Beck, *Voluntary Conduct Automatism, Insanity and Drunkenness* (1966-7), 9 Crim. L.Q. 315.

105 See *R. v. Shaw*, [1938] O.R. 269; [1938] 3 D.L.R. 140; 70 C.C.C. 159.

practitioners to administer psychotherapy in society under supervision. Finally, it would be necessary to condition our judges and magistrates to a rational and somewhat cold-blooded assessment of each individual case, free from the emotionalism that often sways our sentencers towards excessive severity or excessive leniency.

One objection to my proposal would come from the apostles of civil liberties who would point out that the result of a Mental Health Act type or order might be that the offender would be in custody or under supervision for a longer time than he would be if sentences were meted out on the basis of supposed retribution or on an assembly line or tariff basis. It is often urged that the offender might prefer to spend his time in prison rather than come into the hands of a headshrinker.[106] Both of these arguments have a factual foundation. One of the anomalies of our present sentencing policy, if I may use the word policy, is that offenders are often sentenced to imprisonment for terms that are far too short having regard to the degree of risk they create and the persistence of their proclivities. It is true that some forms of criminal conduct cause more nuisance than harm and a balance must be struck between the protection of society from the nuisance and the interests of the offender, which may appear in some cases to require his release before any hope of affecting his attitudes or tendencies can be entertained. We should, I suggest, completely remove some forms of "nuisance" conduct from the category of crime. On the other hand, where criminality occurs, if there is any hope of the success of psychotherapy, one term of reasonable length now might be balanced against a prospect of a series of future similar offences each followed by an inadequate term. We should not allow ourselves to be too much influenced by the type of treatment that the offender would prefer. Most of us prefer ouselves as we are. We resist change, even when it is for our own advantage as well as for that of society. We find personality change very painful. Most offenders find it more painful than maximum security imprisonment and resist it with all their powers just as we do. As long as we exist without doing or threatening undue harm to our neighbours, we may justifiably refuse to submit to "brain washing". When one of us poses a threat of unreasonable harm through conduct which is so reprehensible that it has been categorized as criminal, society is justified in requiring him to submit to procedures designed to change

106 See, e.g. Marriage, in "Review of Crime and Its Treatment in Canada" (1966), 8 Can. J. of Corrections, 300, at p. 308. I once defended a man who refused to allow me to introduce evidence of insanity (which as it happened would not have succeeded) because he preferred to risk a long penitentiary term rather than to go to "Penetang". He got 20 years and even that he considered less severe than the other.

his attitudes and his values and to induce him to seek choices that will lead him to relatively harmless decisions. If, as I believe, the sole justification for punishment of offenders is to eliminate further criminal conduct or at least reduce it to acceptable proportions, I think we are justified in appropriate cases in employing psychotherapy intended to assist in development of a sense of responsibility, rather than conventional imprisonment, to that end.