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The Sentencing of Mentally Disordered Offenders

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THE SENTENCING OF MENTALLY DISORDERED OFFENDERS

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There are no special sentences for mentally disordered offenders to be found in Canada's *Criminal Code*, aside perhaps from the dangerous sexual offender provision[1] and the section disposing of insane accused persons.[2] Nevertheless, mental illness or disorder, though its presence requires no formal adjudication, is a factor which judges are bound to consider before imposing sentence. But while the law is settled that a failure to take due notice of all relevant psychiatric data will provide grounds for appeal,[3] it is by no means clear what effect must be given to an offender's aberration once it has been adverted to.

As a direct result of this dilemma, Canadian courts have, for the most part, endeavoured to tailor the existing *Criminal Code* sanctions to fit the mentally disordered offenders' amorphous dimensions. The result, unfortunately, has been a rather patchy and non-uniform design. By weaving provincial mental health legislation into the fabric of Canadian criminal law, the courts have occasionally succeeded in outfitting disordered offenders with a fashionable alternative to prison denims: straightjackets.

The aim of this paper is to outline the manner in which Canadian courts have attempted to deal with the disposition of mentally abnormal offenders. As will become apparent, the fate of any one such person depends generally on a combination of three factors: the type of offence involved, the nature of the offender's abnormality, and the philosophy of the sentencing judge. In addition to explaining the mechanics of sentencing and enumerating the variety of dispositions available to the courts, the discussion will deal with some ethical problems concerning pre-sentence psychiatric information. In the end, some conclusions will be drawn and an assessment made regarding possible future alterations — both with regard to judicial sentencing policy and the role of psychiatry in the sentencing process.

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[1] 689 (3) Where the court finds that the accused is a dangerous sexual offender it shall, notwithstanding anything in this Act or any other Act of the Parliament of Canada, impose upon the accused a sentence of preventive detention in lieu of any other sentence that might be imposed for the offence of which he was convicted or that was imposed for such offence, or in addition to any sentence that was imposed for such offence if the sentence has expired.

[2] 542(2) Where the accused is found to have been insane at the time when the offence was committed, the court, judge or magistrate before whom the trial is held shall order that he be kept in strict custody in the place and in the manner that the court, judge or magistrate directs, until the pleasure of the Lieutenant Governor of the Province is known.

[3] *R.* v. *Roberts*, [1963] 1 O.R. 280 (C.A.); *R.* v. *Doran* (1972), 5 C.C.C. (2d) 366 (Ont. C.A.).

A. REMAND

When a trial judge wishes to have an offender psychiatrically examined before imposing sentence, he may do so under the authority conferred by sections 543(2) and 543 (2.1) of the *Criminal Code*. Sections 608.2(1) and 608.2(2) supply an identical procedure for the Court of Appeal. An alternative remand procedure, which is open to both trial and appeal court judges, is that provided by provincial legislation such as Ontario's *Mental Health Act*.[4] Although it seems that the Code is more frequently selected,[5] this is rather difficult to understand since *The Mental Health Act* would appear, from a practical standpoint, to be far less cumbersome. While an order under sections 543(2) or 608.2(1) generally requires the "evidence or, where the prosecutor and the accused consent, . . . the report in writing, of at least one duly qualified medical practitioner" to be given in support of the remand,[6] no such requirement exists in section 14(1) of *The Mental Health Act*. Furthermore, the Code is unclear on the procedure involved in obtaining the necessary medical evidence in the first place.[7]

At first blush, there does not appear to be a great deal of difference between the tests which must be satisfied under both pieces of legislation in order for a judge to remand. The Code requires the court to be of the opinion that there is reason to believe that:

> (a) an accused is *mentally ill*, or
> (b) *the balance of the mind of an accused is disturbed* where the accused is a female person charged with an offence arising out of the death of her newly-born child.[8] (emphasis added)

The Mental Health Act, by comparison, may be used wherever the judge "has reason to believe"[9] that the accused "suffers from mental disorder."[10] It is possible that the term "mental disorder" encompasses all of the terms which the Code uses and more. As a result, persons not properly characterized as being "mentally ill" or "unbalanced" may nevertheless be caught by section 14(1). For this reason the provincial legislation may be preferred by followers

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[4] R.S.O. 1970, c. 269.

[5] In 1973 the Clarke Institute of Psychiatry in Toronto admitted 50 patients remanded under the *Criminal Code* as compared with 35 remanded under *The Mental Health Act*. Judges seem to prefer using the Code whenever the accused has been charged under the Code. This may be because of a feeling that the word "offence", where it appears in *The Mental Health Act*, refers only to an offence under provincial legislation (*e.g.*, *The Liquor Control Act*).

[6] Prior to the passage of Bill C-71, no provision was made for the simple report in writing of a medical practitioner.

[7] The writer has been informed, from personal communication with provincial court judges and forensic psychiatrists, that no difficulty really arises. Usually where mental illness is suspected, the offender has been examined long before the dispositional stage.

[8] *Criminal Code*, R.S.C. 1970, c. C-34, s. 543(2).

[9] In *Ex Parte Branco*, [1971] 2 O.R. 575 (H.C.) it was held that although a superior court could decide whether there were reasonable grounds on which this discretion could be exercised, the provincial court judge's exercise of the discretion could not itself be reviewed.

[10] Section 1(f) of the Act defines "mental disorder" as "any disease or disability of the mind."

of Thomas Szasz[11] or by judges who believe that certain offenders, such as mental defectives, can more easily be called disordered than ill.

Although the statutory provisions are silent as to what will constitute sufficient "reason to believe" that an offender fits the pertinent remand requirements, it may be helpful to limit the criteria upon which remand may be ordered. While some might feel psychological screening to be an advisable precaution in the case of all offenders, simple economics would seem to dictate selectivity. For this reason, Walker[12] has given the following categories of offenders priority with respect to remand:

> 1) the mature person who, after years of steady, respectable living, is unexpectedly detected in some 'out of character' offence, such as embezzlement or assault; and, as an extreme case, any first offender over sixty years of age;
> 2) at the other extreme, the offender with a history of persistent anti-social behaviour which fails to respond to ordinary correctives;
> 3) the offender whose offences have an irrational quality about them, especially if they follow a stereotyped pattern (for example, the man who picks up and then assaults prostitutes, or steals only women's clothing);
> 4) the offender who commits serious violence against members of his own family;
> 5) most sexual offenders, apart from those who have simply had intercourse with willing girls just under the age of consent.

In actual practice, judicial use of the psychiatric remand procedures seems to depend upon the personality of the sentencing judge as much as upon that of the offender. Hogarth has noted a direct correlation between the degree to which magistrates perceive mental disorder in offenders and the degree to which they value rehabilitation over the other traditional goals of sentencing.[13] While 44 per cent of those magistrates surveyed considered that none or very few of the offenders appearing before them were mentally ill, 37 per cent felt that a significant minority were, and as many as 14 per cent considered that most offenders were mentally ill.[14] In assessing the data, Hogarth has written:

> Comparisons were made of the penal philosophy scores of magistrates who differed in the degrees of mental illness they perceived. The positive relationship of belief in reformation to the proportion of offenders seen as mentally ill is very

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[11] Szasz maintains that the term "mental illness" is a gross misnomer. In *The Myth of Mental Illness* (Revised ed. New York: Harper and Row, 1974) at x-xi, he has written:

> . . . I maintain that mental illness is a metaphorical disease: that bodily illness stands in the same relation to mental illness as a defective television set stands to a bad television programme. Of course, the word 'sick' is often used metaphorically. We call jokes 'sick', economies 'sick', sometimes even the whole world 'sick'; but only when we call minds sick do we systematically mistake and strategically misinterpret metaphor for fact — and send for the doctor to 'cure' the 'illness'. It is as if a television viewer were to send for a television repairman because he dislikes the programme he sees on the screen.

[12] Walker, *Sentencing in a Rational Society* (Pelican, A-1108, 1972) at 127.

[13] Hogarth, *Sentencing as a Human Process* (Toronto: University of Toronto Press, 1971) at 85.

[14] *Id.* at 84. The views of this latter groups were consistent with the belief of Lord Hale who declared that "doubtless, most persons that are felons . . . are under a degree of partial insanity when they commit these offences."

> strong. In contrast, the amount of mental illness seen is negatively associated with belief in general deterrence, retribution and incapacitation.[15]

At a later point in his research, he has concluded that:

> . . . magistrates concerned about the treatment of offenders are more active in their search for information than magistrates concerned to punish crime for deterrent or retributive purposes.[16]

Once the offender has been remanded where does he go and for how long? Under sections 543(2) and 608.2(1) of the Code, he may be placed in "such custody" as the court, judge or magistrate directs "for observation". Theoretically, this could mean simple incarceration in the lock-up for thirty days. In England it has been suggested that "the remand in custody process is used as a punishment — as a mini-prison sentence in fact."[17] To what extent this goes on in Canada is not known, although the Code's provisions are clearly susceptible of being abused in a like manner. In contrast, section 14(1) of *The Mental Health Act* is more precise in its wording, providing that the accused must be sent to a "psychiatric facility". In addition, section 16 offers the following insurance:

> A judge shall not make an order under section 14 or 15 until he ascertains from the senior physician of a psychiatric facility that the services of the psychiatric facility are available to the person named in the order.[18]

A potential source of difficulty with the Act, however, is that the maximum period of remand is longer here than in the Code. Under sections 543(2.1)(b) and 608.2(2)(b) of the Code, a remand for more than thirty days (with a maximum of sixty days) can only be ordered when supported by the evidence or report of at least one doctor. By section 14(3) of *The Mental Health Act* such evidence is sufficient to commit the accused for an indefinite period of treatment.

Until recently, section 14 was the only remand provision under which examination could take place on an out-patient basis. With the passage of Bill C-71, however, this situation has been remedied. In addition to remanding the accused in custody, the courts are empowered under the *Criminal Code* to "direct an accused to attend, at a place or before a person specified in the order and within a time specified therein, for observation. . . ."[19] The utility of such procedure may be readily seen when one considers the fact that actual examination time normally comprises only a fraction of the remand period.[20] Out-patient examination would seem particularly appropriate for a defendant who is not in actual custody at the time the order is made. As Gunn has

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[15] *Supra*, note 13 at 85.

[16] *Id.* at 238.

[17] Gunn, *Sentencing — As Seen by a Psychiatrist* (1971), 11 Med. Sci. and the Law 95 at 95.

[18] Note that technically this provision relates solely to availability of psychiatric services; it does not really guarantee an accused any right to examination or treatment.

[19] Ss. 543(2)(c) and 608.2(1)(a).

[20] It should be kept in mind, however, that nothing prevents the court from ordering a remand for less than thirty days or from having the accused returned from the psychiatric hospital before the period of remand has expired if the remainder of the time is not required.

pointed out, in cases where probationary out-patient treatment is to be the court's ultimate disposal of the offender, "as little damage as possible will have been done to the patient's social situation and the maximum therapeutic potential preserved."[21]

Regardless of whether the offender is remanded under *The Mental Health Act* or under the Code, the expiration of the thirty or sixty day period by no means ensures his return to the courtroom for sentencing. It is always possible that the judge who has ordered the remand will receive a letter from the psychiatric facility informing him that the offender has been admitted as an "involuntary patient" by virtue of section 8 of *The Mental Health Act*.[22] As indicated by the decision of the Supreme Court of Canada in *Fawcett* v. *Attorney-Gen. for Ontario*,[23] provincial mental health provisions which operate in this fashion are entirely *intra vires*. Even if the offender is in fact returned to the courtroom, he may be certified immediately after sentence has been passed.[24]

One final flaw which should be noted with regard to sections 543(2) and 608.2(1) of the Code is that they do not require the examining psychiatrist to submit a report of what he has discovered about the offender's mental state during the period of "observation". Because observation is in itself useless without such report, common practice is for the doctor to submit one anyway. When remand has been ordered under *The Mental Health Act*, however, section 14(2) requires that "the senior physician shall report in writing to the judge as to the mental condition of the person."

B. PSYCHIATRIC REPORTS

Psychiatrists who are called upon to furnish pre-sentence reports are faced with numerous difficulties. First and foremost is the problem of diagnosis. According to Bartholomew, "[I]t is almost impossible to offer . . . a definite psychiatric diagnosis in the majority of criminals."[25] According to Scott, whom Bartholomew has quoted:

> In those cases selected for psychiatric report a classical diagnosis cannot be made in more than 20 per cent. In the other 80 per cent it is impossible to attach a label any more accurate than 'personality disorder' or 'social maladjustment'. . . .[26]

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[21] *Supra*, note 17 at 96.

[22] 8(1) Any person who,
(a) suffers from mental disorder of a nature or degree so as to require hospitalization in the interests of his own safety or the safety of others; and
(b) is not suitable for admission as an informal patient; may be admitted as an involuntary patient to a psychiatric facility upon application therefore in the prescribed form signed by a physician.

[23] [1964] S.C.R. 625, aff'g (1962), 40 D.L.R. (2d) 942 (Ont. H.C.).

[24] The use of this procedure is discussed later in the text. Sometimes the offender is certified by a psychiatrist present in the courtroom for just such purpose. This is done instantly upon the imposition of sentence.

[25] Bartholomew, *The Psychiatric Report for the Court* [1962] Crim. L.R. 19 at 21.

[26] Scott, *Psychiatric Reports for Magistrates' Courts* (1953), 4 Brit. J. Delinq. 1, quoted by Bartholomew *supra*, note 25 at 21.

While this state of affairs may simply illustrate the understatement that "the science of psychiatry cannot provide absolutely certain answers to many questions",[27] it may also be attributable to the distinct possibility that not all offenders are mentally ill. Unfortunately, however, psychiatrists seem all too often to overlook this contingency. Their reasons for doing so may either be a conscious subscription to Roche's philosophy that "crime is a disturbance of communication, hence a form of mental illness",[28] or else an over-zealous response to the suspicions of the remanding judge. In either case, statistics indicate that persons remanded for psychiatric assessment stand little chance of being found completely normal,[29] despite the examiner's frequent failure to name their illnesses.

Bartholomew has argued that the lack of diagnostic precision on the part of reporting psychiatrists is of no real consequence anyway. The mere affixing of labels such as 'psychopathic personality' or 'borderline defective' to an offender is of no assistance to the sentencing judge. Rather, it is in supplying a general 'dynamic' assessment of the offender's psyche that the examining psychiatrist can be most useful. In essence, a 'dynamic' or 'multi-factorial' diagnosis is one which describes a mental phenomenon in terms of the forces which caused or produced it.[30] The formulation of such a diagnosis naturally requires a great deal of information. In this regard, psychiatrists are oftentimes impeded by the sentencing judges themselves. All too often, Bartholomew has complained, judges fail to supply adequate information concerning their reasons for remanding the accused in the first place:

> Time and again one reads [on] the form sent from the court to the medical officer under the heading 'Reasons which led the court to request a report on the accused's state of mind' such phrases as 'Demeanour in court'; 'Previous mental history' (without amplification); 'Nature of offence' (this included all sexual offences without differentiation). Phrases such as 'Not known' and 'For the guidance of the court' demonstrate even more clearly the lack of interest and concern that courts can and do display.[31]

In gathering the information he needs, the psychiatrist, in addition to examining the accused and running him through a battery of psychological tests, may require previous hospital, prison or police records. He may also consult with the offender's family and friends. Although, needless to say, a great deal of hearsay will have transpired during the course of the doctor's

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[27] Roberts, *Some Observations on the Problems of the Forensic Psychiatrist* (1965), Wis. L. Rev, 240 at 244.

[28] Roche, *The Criminal Mind: A Study of Communication Between Criminal Law and Psychiatry* (New York: Farrar, Strauss and Cudahy, 1958) at 241. For criticism of this philosophy, see Szasz, *Law Liberty and Psychiatry: An Inquiry into the Social Uses of Mental Health Practices* (New York: Macmillan, 1963) at 91-108.

[29] In a study made in 1966 in England, it was discovered that only 29% of those persons remanded (143 out of a sample of 494) were considered by the examining doctors to be mentally normal. See, Sparks, *The Decision to Remand for Mental Examination* (1966), 6 Brit. J. Criminology 6 at 10, table II.

[30] Fenichel, *The Psychoanalytic Theory of Neuroses* Routledge and Kegan, Paul. (1946) at 11, cited by Bartholomew, *supra*, note 25 at 22.

[31] *Supra*, note 25 at 30.

inquiries, the *Wilband*[32] case seems to have eliminated any and all problems regarding the admissibility of evidence resulting therefrom.

The reporting psychiatrist's troubles are by no means over once he has arrived at a diagnosis. A court does not, after all, remand an offender simply to learn of his 'repressed libidinous fantasies' or 'latent homicidal tendencies'. What the judge wants to know is whether he is treatable and whether he is dangerous. It is of little comfort to know that the offender's uncontrollable urge to set fire to chickens stems from a neurotic fear of liverwurst.

Although in *Regina* v. *Robinson*[33] the court was told that there was a 66-70 per cent chance of the offender's being "cured" by psychotherapy, such predictions are rare indeed. The cautious psychiatrist is more likely to maintain that "one really cannot give prognostic 'odds' as to the efficacy of psychotherapy";[34] he prefers to state the minimum period of time which would be required to treat the patient effectively. But even this type of estimate should be taken with a grain of salt, for there is no guarantee that the doctor who offers such a prediction will be the one who ultimately treats the offender.

Regardless of whether or not a satisfactory answer can be given, it is at least legitimate to question a physician concerning the results one might expect from the therapy he offers. It is doubtful, however, whether an individual's dangerousness is a matter which a physician ought properly to be called on to assess. Unlike curability, dangerousness is not a subject ostensibly within his field of expertise. It is no wonder, therefore, that psychiatrists feel uncomfortable about expressing opinions on the topic. McCaldon has stated:

> As a psychiatrist I am frequently asked to make an assessment with regard to possible future dangerousness of a patient, and I must confess that I can find no firm psychiatric criteria for so doing. . . . It is unlikely that there are any psychiatrists who can predict dangerousness in a number of individuals with a high level of accuracy.[35]

It is, for that matter, unlikely that anyone possesses what could be called an expertise in the area of gauging dangerousness. As Halleck has pointed out:

> Research in the area of dangerous behaviour (other than generalizations from case material) is practically nonexistent. Predictive studies which have examined the probability of recidivism have not focused on the issue of dangerousness. If the psychiatrist or any other behavioural scientist were asked to show proof of his predictive skills, objective data could not be offered.[36]

For this reason, Morris has argued that dangerousness ought to be rejected as a basis for imposing sentences of imprisonment.[37] In doing so, he would

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[32] [1967] S.C.R. 14.

[33] [1975] 19 C.C.C. (2d) 193 (Ont. C.A.) at 196.

[34] Bartholomew, *Some Problems of the Psychiatrist in Relation to Sentencing* (1973), 15 Crim. L.Q. 325 at 334.

[35] McCaldon, *Reflections on Sentencing* (1974), 16 Can. J. Crimin. and Corr. 291 at 295.

[36] Halleck, *Psychiatry and the Dilemmas of Crime: A Study of Causes, Punishment and Treatment* (Berkeley: University of California Press, 1971) at 314.

[37] Morris, *The Future of Imprisonment* (Chicago: University of Chicago Press, 1974) at 62.

seem to have adopted the philosophy of Wharton, who described the preventive theory of criminal justice as one which "contradicts one of the fundamental maxims of English common law, by which not a tendency to crime, but simply crime itself can be made the subject of a criminal issue."[38]

Those who adhere to the validity of 'dangerousness' as a workable criminological concept have offered us little in the way of criteria for detecting its presence. Psychiatry's time-honoured epitome of evil incarnate is the ubiquitous psychopath. Also called the sociopath, our elusive stereotype has been credited[39] with the following rather unflattering attributes:

1) Superficial charm and good "intelligence".
2) Absence of delusions and other signs of irrational thinking.
3) Absence of "nervousness" or psycho-neurotic manifestations.
4) Unreliability.
5) Untruthfulness and insincerity.
6) Lack of remorse or shame.
7) Inadequately motivated anti-social behaviour.
8) Poor judgment and failure to learn by experience.
9) Pathological egocentricity and incapacity for love.
10) General poverty in major affective reactions.
11) Specific loss of insight.
12) Unresponsiveness in general inter-personal relations.
13) Fantastic and uninviting behaviour with drink and sometimes without.
14) Suicide rarely carried out.
15) Sex life impersonal, trivial and poorly integrated.
16) Failure to follow any life plan.

None of us is perfect.

Aware that few really dangerous persons wear "I AM A PSYCHOPATH" buttons, McCaldon[40] had devised his own checklist of ingredients for gauging dangerousness. The characteristics, though they may not add up to stark raving psychopathy, are hardly what one looks for in the ideal baby-sitter:

1) A history of violent outbursts, especially if such history involves cruelty to animals.
2) Fragmented basic relationships such as broken home, unhappy marriage, etc.
3) Exposure to hostile or anti-social environment.
4) Violence is seen by the offender as one of the means of his expressing self-esteem.
5) A blockage or lack of attainment in normal supportive relationships such as love, sexual relationships, work, friends, etc.
6) A rather schizoid or border-line psychotic mental state at the time of examination.

The problem with these criteria, as with those relating to psychopathy, is that their relevance in the prediction of future criminal behaviour is not supported by empirical data.

Perhaps the most serious ethical issue facing a reporting psychiatrist

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[38] Wharton, *Criminal Law* (12th ed., 1932) s. 2.

[39] Cleckley, *The Mask of Sanity* (St. Louis: Mosby, 1955) at 380-81, cited in Nemeth, *Psychopathic Personality — Its Relevance in the Correctional After Care Agency* (1961), 3 Can. J. Corr. at 128-29.

[40] *Supra*, note 35 at 295-96.

arises after his assessments of the offender's curability and dangerousness have been made. It concerns the inclusion in his report of recommendations pertaining to the actual disposition of the offender. Although some authorities regard it as clearly improper for a psychiatrist to advocate the imposition of one sentence over another,[41] Bartholomew has maintained that:

> . . . a recommendation is implicit in the initial request for a medical and/or psychiatric report. To suppose that the court only requests a diagnostic formulation but does not want any recommendations as to possible 'treatment', or the best method of dealing with the case, is hardly to the credit of the court and would be utterly illogical.[42]

Insofar as an opinion regarding the most effective form of psychotherapy would be difficult to divorce from an endorsement of that treatment, Bartholomew is probably correct in asserting the illogicality of such separation. And it would, of course, be odd for an examining psychiatrist to characterize an individual as treatable without naming the treatment he has in mind. However, the assertion that psychiatrists are logically entitled to advise the court as to the relative values of all forms of sentence is one which must be seriously questioned.

Scott has asserted[43] that psychiatrists should never include recommendations for punishment in their reports to the court. The problem with applying this rule, however, lies in the susceptability of the word "punishment" to divergent interpretations. What an offender views as punishment may be seen as treatment by the psychiatrist. When dealing in the area of psychotherapy it is often difficult (if not impossible) to distinguish the two. Indeed, citing the use of aversion therapy, Gunn has observed that "punishment is of course not entirely alien to psychiatry."[44] Because many psychiatrists view punishment as therapeutic in some circumstances, they may feel unrestrained in recommending whatever form of disposition they deem appropriate in the interests of rehabilitation. For this reason, Bartholomew has asserted the legitimacy of psychiatric recommendations for imprisonment:

> . . . it must be realized that imprisonment is not simply what is left over when all other sanctions have been tried and found to fail or have been rejected in the first place. Imprisonment can be therapeutic and rehabilitative in a number of cases. . . .[45]

Psychiatrists who view punishment as therapeutic consider one of its uses to be the alleviation of guilt feelings on the part of certain offenders.[46] In illustrating this theory Gunn has reported the following case history:

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[41] See, Page, *Sentence of the Court* (London: Faber and Faber, 1948) at 170, cited by Bartholomew *supra*, note 25 at 23.

[42] *Supra*, note 25 at 23. Citing a study made by Radzinowicz, *Sexual Offences* (London: MacMillan, 1957) at 74, the author notes that most psychiatric reports do in fact contain recommendations as to the disposal of the prisoner.

[43] Scott, *Psychiatric Reports for Magistrates' Courts* (1953), 4 Brit. J. Delinq. 1, cited by Bartholomew, *supra*, note 25 at 24.

[44] Gunn, *Sentencing — As Seen by a Psychiatrist* (1971), 11 Med. Sci. and the Law 95 at 97.

[45] *Supra*, note 25 at 24-25.

[46] Gunn, *supra*, note 44 at 97.

> A man, many years ago, remonstrated with his wife's lover, the inevitable fight ensued and the interloper was killed. The man was subsequently convicted of manslaughter. At the time he suffered unbearable guilt and prayed for a stiff punishment. The court took a more lenient view of his behaviour and gave him a conditional discharge. He was amazed and appalled. He felt that he had been deprived of a chance to redeem himself and ran away from home and drowned his sorrows in drink. Since that time he has been a severe and persistent alcoholic and is convinced that if he had a reasonable punishment — say two or three years in prison — he would not have deteriorated.[47]

With all due respect to the chronicler, the credibility of this little melodrama seems a bit thin. One fails to see how staring at a cockroach crawling across the ceiling of his jail cell for three years would have brightened up the offender's outlook on life.

Even if one accepts the legitimacy of therapeutic punishment, a psychiatrist's expertise in matters of psychic rehabilitation will not in itself justify all recommendations he makes with regard to sentence. As the case of *R.* v. *Doucet*[48] illustrates, a psychiatrist may well base his advice on entirely unrelated considerations. In *Doucet* the reporting doctors advocated a sentence of imprisonment for the purposes of general as well as specific deterrence.

A final problem with psychiatric reports concerns their confidentiality. Until the 1968-69 parliamentary session, the general rule in this regard was that set out in *Rex* v. *Benson and Stevenson*,[49] a decision of the British Columbia Court of Appeal. In that case it was held that offenders should be informed of the substance of any detrimental information contained in presentence reports, in order that they might explain or deny it. A crucial exception to this rule was made, however, with regard to psychiatric data, the court saying:

> In an earlier part of these reasons I referred to an observation by Goddard L.C.J. in *R.* v. *Dickson* in dealing with the statutory obligation to furnish the prisoner or his counsel with a copy of the representations made to the Court by the Prison Commissioners. He said in part: 'In some cases I think it very undesirable, because it may sometimes give him ideas about his mental condition which he perhaps should not know.' I am in complete agreement with that statement, — if I may say so with deference. And for this reason: The fact that a convicted person is suffering from some mental disorder is not a factor which should in ordinary cases influence a Court to impose a higher sentence than would be imposed upon a man of normal mentality. *It is not a fact damaging or detrimental to him in the sense that it would lead to the imposition of a heavy sentence in the ordinary run of cases.*
>
> There are cases, involving, for instance, sexual crimes, where the Court might well consider the mental instability of the convict renders him a menace to society but it seems to me in that class of an allegation of that fact contained in a Probation Officer's report is of little value standing alone. A psychiatric examination conducted by a doctor qualified in that field is the method to determine that fact. *The examining doctor would be the best judge as to whether or not the result of his examination should be fully disclosed to the convict.*[50] (emphasis added)

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[47] *Id.*

[48] [1971] 1 O.R. 705 (C.A.) at 706.

[49] (1951), 100 C.C.C. 247.

[50] *Id.* at 261.

With the enactment of section 662(2) of the present *Criminal Code* the above exception would seem to have been effectively extinguished insofar as it applied to psychiatric information in the hands of the probation officer. Section 662 reads:

> (1) Where an accused, other than a corporation, pleads guilty to or is found guilty of an offence, a probation officer shall, if required to do so by a court, prepare and file with the court a report in writing relating to the accused for the purpose of assisting the court in imposing sentence or in determining whether the accused should be discharged pursuant to section 662.1.
> (2) Where a report is filed with the court under subsection (1), the clerk of the court shall forthwith cause a copy of the report to be provided to the accused or his counsel and to the prosecutor.

It is to be noted that this section makes no reference whatsoever to information filed by persons other than the probation officer. With respect to reports filed by the examining psychiatrist personally, the *Benson and Stevenson* exception would therefore appear to have been left intact. Supportive of this view is the wording of section 17 of Ontario's *Mental Health Act*. It provides:

> Notwithstanding this or any other Act or any regulation made under any other Act, the senior physician may report *all or any part* of the information compiled by the psychiatric facility to any person where, *in the opinion of the senior physician*, it is in the best interests of the person who is the subject of an order made under section 14 or 15.

C. POSSIBLE SENTENCES

Nowadays it is commonly assumed in the case of mentally disordered offenders that rehabilitation is the prime consideration for the sentencing judge and that it takes precedence over traditional punitive goals. Thomas has in fact suggested that:

> Where the offender can be shown to be in need of psychiatric treatment, and the necessary treatment is available in an appropriate setting, the Court will normally make an appropriate order *without regard to* considerations of deterrence and retribution. . . . There are some cases in which this approach is not evident, but they are clearly exceptional.[51] (emphasis added)

If this is an accurate description of sentencing policy in England, it is doubtful whether it reflects a universally accepted philosophy or practice. Because conviction has historically denoted responsibility, North American jurists have shown reluctance to depart from the logic that those who are mentally blameworthy[52] should be punished. As Halleck has noted, "punishability is equated with the criminal's responsibility for his actions."[53]

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[51] Thomas, *Principles of Sentencing* (London: Heinemann, 1970) at 257.

[52] *I.e.*, those who, in the case of most offences, have been adjudged to have had *mens rea*.

[53] *Supra*, note 36 at 207. Even in England, where the rehabilitative ideal is said to flourish, one still finds judicial reasoning like that of Lord Parker, C.J. in *Regina* v. *Morris*, [1961] 2 Q.B. 237 at 243:

> Of course there may be cases where, although there is a substantial impairment of responsibility, the prisoner is shown on the particular facts of the case nevertheless to have some responsibility for the act he has done, *for which he must be punished*. . . . (emphasis added)

More than twenty years ago an American psychoanalyst named Waelder suggested a movement away from the imposition of punitive sanctions as an inevitable consequence of conviction. He stated:

> It seems advisable, first of all, to reformulate our laws in such a way that they are no longer focussed on punishment of crime with other dispositions taking their place as exceptions from the rule . . .[54]

He went on to recommend[55] the following tables as a guide to sentencing:

Symbol	Diagnostic Characterization	Disposition
1, 1, 1	Dangerous Deterrable Treatable	Punishment and Treatment
1, 1, 2	Dangerous Deterrable Not treatable	Punishment
1, 2, 1	Dangerous Not deterrable Treatable	Preventive Custody and Treatment
1, 2, 2	Dangerous Not deterrable Not treatable	Preventive Custody
2, 1, 1	Not dangerous Deterrable Treatable	Punishment with Probationary Period and Treatment
2, 1, 2	Not dangerous Deterrable Not treatable	Punishment, perhaps with Probationary Period
2, 2, 2	Not dangerous Not deterrable Not treatable	Release

It is submitted that Canada's courts have not yet fully embraced the rehabilitative ideal. Whether or not they articulate their reasons, Canadian judges seem to be operating on a rationale more closely resembling that proposed by Waelder than the one which Thomas has described. Consequently, the sanctions to which mentally abnormal offenders are liable today may entail anything from simple punishment, to elaborate psychotherapy, to a combination of the two.

1. *Fine*

This form of sanction has, on occasion, been employed as a method of dealing with abnormal persons convicted of relatively minor offences. Clearly

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[54] Waelder, *Psychiatry and the Problem of Criminal Responsibility* (1952), 101 U. of Penn. L. Rev. 378 at 389.

[55] *Id.* at 390.

the purpose behind the imposition of a fine is punitive rather than rehabilitative. By punishing the offender, the Court seeks only to deter such person from exhibiting the symptoms of his supposed affliction in an unlawful manner; it is not concerned with bringing about a 'cure'.

The offence of committing an act of gross indecency[56] in public[57] is one for which some judges have considered the levying of a fine suitable. In *R.* v. *Five Accused Persons*[58] Rice, Prov. Ct. J., imposed $100 and $200 fines on several confirmed homosexuals, stating his reasons for so doing as follows:

> I can see no purpose in suspending sentence. The accused are confirmed homosexualists and have not indicated that they intend to fight off this disease. Even if they did, I doubt whether they could. I do not know how far a successful medical treatment has progressed in this field. . . . I have come to the conclusion that until some other mode of punishment is devised a fine with the alternative of a gaol sentence should be imposed on first offenders — and all the accused are such. There is no need for me to deal with second offenders at this stage. As long as this revolting and sickening offence is a crime, the law can only punish; it is not for courts to prescribe treatment; this is a matter for medical science. It is also not a matter for the courts to say how and where these unfortunates should be incarcerated. There are experts in that field.[59]

Similarly, in *R.* v. *Boisvert and Lupien*[60] fines of $100 and $750 were imposed by a British Columbia County Court for an offence under section 157. It is important to note that this section provides for a maximum of five years imprisonment, thus making fine possible *in lieu of* imprisonment under section 646(1) of the Code.[61] Where the offence is a more serious one and is punishable by more than five years imprisonment, a fine may be imposed only *in addition to* another authorized punishment.[62] Thus in *R.* v. *Marple*[63] four defendants convicted of indecent assault on a male person[64] were given

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[56] *Criminal Code, supra,* note 8, s. 157.

[57] S. 158 of the Code provides in part:

158.(1) Sections 155 and 157 do not apply to any act committed in private between
(a) a husband and his wife, or
(b) any two persons each of whom is twenty-one years or more of age, both of whom consent to the commission of the act.
(2) For the purposes of subsection (1),
(a) an act shall be deemed not to have been committed in private if it is committed in a public place, or if more than two persons take part or are present.

[58] (1961), 4 Crim. L.Q. 124 (Man. Prov. Ct.).

[59] *Id.* at 124-25.

[60] The decision on sentence is reported by Sanders, *Sentencing of Homosexual Offenders* (1967-68) 10 Crim. L.Q. 25 at 29. The case of *Regina* v. *Lupien* reached the Supreme Court of Canada on a point of expert evidence and is reported in [1970] S.C.R. 263.

[61] 646(1) An accused who is convicted of an indictable offence punishable with imprisonment for five years or less may be fined in addition to or in lieu of any other punishment that is authorized, but an accused shall not be fined in lieu of imprisonment where the offence of which he is convicted is punishable by a minimum term of imprisonment.

[62] Section 646(2) of the Code provides:

> (2) An accused who is convicted of an indictable offence punishable with imprisonment for more than five years may be fined in addition to, but not in lieu of, any other punishment that is authorized.

[63] (1973), 6 N.S.R. (2d) 389 (C.A.).

[64] Section 156 provides a maximum sentence of ten years for this offence.

a perfunctory prison term of one day and fined in the amount of $500. On appeal by the Crown, the Nova Scotia Court of Appeal refused to impose a longer term of imprisonment on the grounds that imprisonment would not rehabilitate the offenders and that the fine constituted an adequate deterrent. In the more recent case of *R.* v. *Dobson*[65] an individual convicted of buggery under section 155 (which carries a maximum of fourteen years) was sentenced *to one day's imprisonment* to be followed by a three year probation period and was ordered to pay a $600 fine as well. While the trial judge's purpose in handing down this sentence was clearly a punitive one, it is interesting that the Nova Scotia Court of Appeal saw fit to vary the probation order by making psychiatric treatment a further condition thereof. In doing so, the Court of Appeal obviously saw nothing contradictory in the aims of punishment and rehabilitation.

2. *Probation*

(a) *Following imprisonment*

Judicial recognition that an offender requires psychiatric attention does not necessarily result in the abandonment of such penological considerations as deterrence and retribution. Waelder has pointed out, however, that rehabilitation is generally made more difficult as deterrent or retributive punishment is increased.[66] Capital punishment, for example, tends to make rehabilitation impossible. But short of this ultimate sanction, terms of imprisonment have been considered by judges as not altogether incompatible with the rehabilitative ideal. As Waelder has put it:

> Whenever our goals conflict, we have to weigh how much of each of these purposes can be achieved and how much sacrifice in terms of one goal is necessary for the partial realization of another one.[67]

It has been argued with great force that the simultaneous combination of punishment and treatment within a penal institution is counterproductive in terms of rehabilitation.[68] Prison, after all, is hardly the ideal therapeutic environment. It is perhaps for this reason, therefore, that some courts have adopted the 'punish now, treat later' approach to sentencing. Utilizing the authority conferred on them by sections 663(1)(b)[69] and 663

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[65] (1975), 11 N.S.R. (2d) 81 (N.S.S.C.A.D.).

[66] *Supra*, note 54 at 388.

[67] *Id.* at 388-89.

[68] *Supra*, note 36 at 286, where

> The psychiatrist who ventures to offer his services to a prison . . . is dismayed to find himself part of a system that is dedicated to the infliction of psychological pain. In fact, the prison environment is almost diabolically conceived to force the offender to experience the pangs of what many psychiatrists would describe as mental illness. A brief look at the prison environment will indicate that it contains the most pernicious factors that are listed as causes of mental illness in our psychiatric textbooks.

[69] 663(1) Where an accused is convicted of an offence the court may, having regard to the age and character of the accused, the nature of the offence and the circumstances surrounding its commission, . . .

> (b) in addition to finding the accused or sentencing him to imprisonment, whether in default or payment of a fine or otherwise, for a term not exceeding two years, direct that the accused comply with the conditions prescribed in a probation order; . . . .

(2)(h),[70] judges have chosen to place suitable offenders on probation, making psychiatric treatment (usually on an out-patient basis) a condition thereof, but only *after* they have served short terms of imprisonment. *R.* v. *De Coste*[71] is a case in point. There the defendant pleaded guilty to two charges of indecent assault and was sentenced by the trial court to eighteen months imprisonment. On appeal, the Nova Scotia Court of Appeal took notice of the fact that he had previously been a psychiatric patient and was diagnosed as schizophrenic. The sentence was varied as follows:

> In view of all the circumstances of this case, including the fact that the appellant has no previous record, we consider that the protection of the public would best be served here by making every effort *consistent with observance of the principle of deterrence* to ensure that the appellant obtain further psychiatric treatment as soon as possible.
>
> It is the unanimous opinion of the Court that the sentence be varied to three months in the Halifax County Correction Centre, that the appellant receive psychiatric treatment forthwith, and that he be placed on probation for a period of two years and comply with the conditions of a probation order which shall include those set out in s. 663(2)(a), (d), (f) and (g) of the *Code*, and the further condition, which we regard as of the utmost importance, that he attend and receive such psychiatric treatment as the probation officer shall arrange.[72] (emphasis added)

(b) *Following a conditional discharge or suspended sentence*

Sections 662.1(2) and 663(1)(a) provide for the imposition of a probation order in cases where the accused has received a conditional discharge or suspended sentence, respectively. Resort to this form of disposition is an obvious sign of judicial adoption of the treatment model. Judges most commonly use this alternative in the case of persons convicted of non-violent sexual offences who are not considered a sufficient danger to the community to require imprisonment. Such sentence has, for example, been employed in cases like *R.* v. *Holte and Landry*,[73] *R.* v. *La Chance and Bliss*,[74] *R.* v. *Desjarlais and Ferguson*[75] and *R.* v. *Herrmann and Singer*[76] as a method of dealing with homosexuals convicted of acts of gross indecency in public. It has also been used with great frequency in the sentencing of pedophiles. In the case of *Regina* v. *Doran*[77] a school teacher who had been convicted on two charges of indecently assaulting young girls had been sentenced to a prison term of

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[70] (2) The following conditions shall be deemed to be prescribed in a probation order, namely, that the accused shall keep the peace and be of good behaviour and shall appear before the court when required to do so by the court, and, in addition, the court may prescribe as conditions in a probation order that the accused shall do any one or more of the following things specified in the order, namely, . . .

(h) comply with such other reasonable conditions as the court considers desirable for securing the good conduct of the accused and for preventing a repetition by him of the same offence or the commission of other offences.

[71] (1974), 10 N.S.R. (2d) 94 (N.S.S.C.A.D.).

[72] *Id.* at 95-96.

[73] Unreported but cited by Sanders, *supra*, note 60 at 27.

[74] *Id.*

[75] *Id.*

[76] *Id.*

[77] [1971] 2 O.R. 405 (C.A.).

twelve months definite and six months indeterminate. On appeal the sentence was varied to time served and the accused placed on two years probation on the condition that he submit to treatment on an out-patient basis at Toronto's Clarke Institute. The Court rested its decision upon the following line of reasoning:

> We have before us material not presented to the trial judge which disclosed that if the appellant were to continue his treatment with Dr. Tisdall and also take treatment at the Clarke Institute of Psychiatry the chance of being cured is favourable. If such treatment outside the prison is likely to effect such a cure, and his imprisonment may not, we think that it is in the general interest of society to have him treated rather than imprisoned.[78]

This statement represents what is perhaps the classic rationale behind the use of probationary psychiatric treatment. It articulates the widely held belief that psychotherapy, if it is to be effective at all, is most properly conducted outside the prison environment.[79] Recognizing that the locking of an individual behind bars may not be the ideal way to effect his healthy readjustment to society, it advances an alternative method of psychic rehabilitation which, though coerced, seems rather more workable.

The assumption that compulsory psychiatric treatment is either more efficacious or more ethical when the coercive force (in this case, the *threat* of imprisonment) remains hidden, is one which invites examination. With respect to coerced therapy generally, Jonas Rappeport has asserted that "enforced treatment is nonetheless treatment and can, in fact, produce changes which are desirable from the standpoint of the individual and society."[80] Regarding the effectiveness of probationary treatment on an out-patient basis he has made the following observation:

> The sex offender statistics published by Turner and Mohr from Toronto[81] and by Peters in Philadelphia, and in the initial data that we have developed from almost two years of an enforced group therapy program, have indicated that when close probation supervision forces patients to attend, very satisfactory results can be obtained by outpatient treatment of those with repeated offences. Those clinics that have no means of enforcing attendance at treatment sessions have repeatedly poor results.[82]

In a similar vein, Melitta Schmideberg has posited that offenders rarely become internally motivated toward rehabilitation unless acted upon by external forces:

> Rehabilitation is possible only if the offender wishes to change. To make the very great effort which is necessary the offender needs a strong motivation. This usually stems from a deterrent that has really shaken him. Thus, *rehabilitation depends on*

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[78] *Id.* at 406.

[79] See, *R.* v. *Hough*, [1965] Crim. L.R. 665 where England's Court of Criminal Appeal utilized probationary psychotherapy in express recognition of the fact that imprisonment would prejudice the chances of therapy being successful.

[80] Rappeport, *Enforced Treatment — Is It Treatment?* (1974), 2 Bulletin of the American Academy of Psychiatry and the Law 148 at 148.

[81] The author cites Turner and Mohr, *Pedophilia and Exhibitionism* (Toronto: U. of Toronto Press).

[82] *Supra*, note 80 at 150.

> *the (open or implied) threat on the one hand, and on the hope on the other.*[83] (emphasis added)

Unfortunately, reasoning of this sort leads us into some rather serious legal and ethical difficulties. Can an offender who has been coerced into treatment ever be said to have given his voluntary informed consent thereto?[84] Curiously enough, Schmideberg's very choice of words is strongly reminiscent of the familiar legal test for assessing the voluntariness of confessions. In *Walker* v. *The King*[85] the Supreme Court of Canada decided that any "fear of prejudice or hope of advantage held out by a person in authority" would vitiate the essential element of volition. By analogy, the hope and fear evoked by the sentencing judge who makes psychotherapy a condition of probation would seem to negative the offender's consent to such treatment.[86] On the other hand, it may be argued that the probationer's predicament needn't negative his capacity to consent at all. He may sincerely wish to be treated.[87] Why should the threat of imprisonment negate freedom of choice? Citizens who are not on probation are also threatened by imprisonment, yet can it be said that whenever persons obey the law they are doing so involuntarily? Hopefully, it is not merely legal constraint which prevents a person from attacking his neighbour with a chain saw!

So much for the legal arguments. As an ethical justification for coerced psychotherapy, Rappeport has offered the traditional common sense argument:

> It has generally been accepted and recognized that the criminal convicted of a crime against persons may not have a right to continue such behaviour and remain free. The law, whose very essence is the protection of society, has a right to prevent him from continuing such behaviour by incarcerating him or, at least, placing him under supervision. It would then seem to follow that the law also has the right to force him to enter a treatment program which will change his behaviour so that he no longer harms other persons.[88]

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[83] Schmideberg, *Re-evaluating the Concepts of Rehabilitation and Punishment* (1968), 12 Internat. J. Offender Therapy 25. This philosophy is not new amongst criminologists. In 1895 Wines wrote that "no treatment will produce the best result unless the consent and cooperation of the criminal patient are secured. For this an adequate motive . . . is essential . . . the hope of freedom. . . ."

[84] From basic principles, it is clear that medical treatment in the absence of prior voluntary informed consent will generally constitute battery: *Younts* v. *St. Francis Hospital and School of Nursing, Inc.* (1970), 205 Kan. 292; *Mohr* v. *Williams* (1905), 95 Minn. 261; *Pratt* v. *Davis* (1906), 224 Ill. 300; *Tabor* v. *Scobel* (1952), 254 S.W. 2d 474 (Ky. C.A.); *Lacey* v. *Laird* (1956), 166 Ohio St. 12; *Rolater* v. *Strain* (1914), 39 Okla. 572. Nor does the offender's status as such dispense with the necessity of obtaining such consent: *Kaimowitz et al* v. *Department of Mental Health (Mich.)*, unreported, June 10, 1973, No. 73-19434-AW (Wayne Co. Circuit Ct.).

[85] [1939] S.C.R. 214 at 217, *per* Duff, C.J.C.

[86] Thus rendering the psychotherapist liable to civil action?

[87] In *Regina* v. *Leech*, [1973] 1 W.W.R. 744 (Alta. S.C.) at 756 a psychiatric witness testified:

> As a matter of fact [the accused] begged me for psychiatric help. He said that he was frightened if he went to prison that when he would get out he might repeat these acts, and he wanted some form of treatment whereby he would not act in a similar manner.

[88] *Supra*, note 80 at 149.

The problem with this statement as an expression of general policy is that it makes no distinction between the gravity of different offences. It suggests that an individual's "right to be different", as Kittrie has called it, is forfeited upon the commission of any crime, regardless of how trivial it might be.[89]

Although there may be legal as well as moral limitations upon the State's right to alter criminal behaviour,[90] the risk of probationary psychotherapy exceeding those limits is no doubt decreased (owing to diminished opportunity) from that which exists in the case of in-patient psychotherapy. Nevertheless it is significant that some courts have preferred not to make psychiatric treatment a strict condition of probation even where they have felt such treatment advisable. In an apparent attempt to remove the coercive element from the psychiatrist-patient relationship, they have merely offered their recommendation that the probationer undergo psychotherapy. Thus in *Regina* v. *H.*[91] an Ontario County Court sentenced a pedophile who had been convicted on several counts of indecent assault to twelve months probation with only the usual conditions. The Court further advised the accused, however, to 'voluntarily' attend as an out-patient at Toronto's Forensic Clinic. In *Regina* v. *Allen*[92] where the offender had been sentenced on similar charges to two years imprisonment, the British Columbia Court of Appeal reduced the sentence to time served without imposing probation at all. In stating its reasons the Court noted that the appellant had "recognized the urgency of continuing regular psychiatric treatment."[93]

Implicit in the use of out-patient psychotherapy as an alternative to imprisonment is a rejection by the Court of general deterrence as a silent consideration in the circumstances. In *Doran* the Court felt that:

> [d]eterrence in this case is of small moment because the Court is of the view that the appellant suffers from an illness, as do all pedophiles; they are not deterred by punishment to others.[94]

This is not to say, however, that probationary psychiatric treatment may be ordered in the case of all non-deterrable offenders. Before selecting this form of sentence, the court will generally require assurance that the accused's condition is treatable[95] and that his being at large will not unduly endanger the

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[89] Rappeport has stated simply (at 149) that "[w]hile the mentally ill may, in Nicholas Kittrie's terms, have a right to be different, this right may be allowed only as long as this difference does not 'interfere' with someone else."

[90] See, *supra*, note 84. See, also, *Knecht* v. *Gillman* (1973), 488 F. 2d 1136 (8th Cir.) where aversive therapy was challenged as being cruel and unusual punishment. There the court held: (1) that the mere characterization of a drug's administration as "treatment" did not make it immune from Eighth Amendment scrutiny; and (2) that use of an emetic drug as an "aversive stimulus" constituted cruel and unusual punishment unless voluntary informed consent were first obtained. No Canadian cases have yet arisen, however, in which behaviour therapy has been challenged under section 2(b) of the *Canadian Bill of Rights*.

[91] (1965-66), 8 Crim. L.Q. 11.

[92] (1954), 108 C.C.C. 239.

[93] *Id.* at 244.

[94] *Supra*, note 77 at 407.

[95] See, the cases of *Hardy*, *Silver* and *Wyer*, cited by Thomas, *supra*, note 51 at 259-60 n. 5.

public.[96] Furthermore, the offender must meet the requirements of eligibility contained in the Code's conditional discharge or suspended sentence provisions. The former[97] excludes persons found guilty of offences punishable by a minimum term, fourteen years, life, or death; the latter[98] excludes those convicted of crimes for which a minimum punishment is prescribed. This limitation on the use of probation would seem to indicate an unwillingness on the part of Parliament to abandon retribution in the case of more serious offences, regardless of the offender's mental state. Interestingly, the gravity of the crime does not seem to be a relevant consideration in England; probation orders have been imposed for offences such as arson[99] and attempted murder.[100]

Apart from the ethical problems involved in making psychotherapy a condition of probation, there are several practical difficulties inherent in the use of this form of disposition. To begin with, although the Code allows under section 663(2)(h) for psychiatric treatment to be made a condition of probation, it contains no provision which compels the psychiatric institution to accept the probationer as a patient. This means that unless the reporting psychiatrist is in a position to know for certain that a particular clinic or hospital will accept the offender if released on probation, the individual runs the risk of involuntarily violating his probation.[101] In England such risk is eliminated in part by section 4 of the *Criminal Justice Act*, 1948 (as amended by Schedule 7 to the *Mental Health Act*, 1959), which provides that the court must be satisfied that suitable arrangements have been made before including in a probation order a requirement that the offender submit to in-patient treatment.

Another potential problem lies in the fact that the psychiatrist who reports to the sentencing court needn't be the one in whose care the offender will be released. Although he might consider the accused suitable for treatment, the facility to whom he is eventually referred may disagree and discharge him from treatment after one session.[102] The result, once again, is that the offender may be placed in violation of his probation. A similar situation may occur even where the reporting psychiatrist is in fact the one who eventually undertakes to treat the accused. Once released, the offender may discover that the doctor's busy schedule allows him to see the accused less frequently than anticipated.[103]

3. *Imprisonment*

(a) *With no special interest in treatment*

Prison sentences, unaccompanied by any particular recommendation for treatment, are frequently given to offenders whom the courts feel to be

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[96] See, *R.* v. *Greedy*, [1964] Crim. L.R. 669 and *R.* v. *Cave*, [1965] Crim. L.R. 448.

[97] S. 662.1(1).

[98] S. 663(1)(a).

[99] *R.* v. *Rideout*, cited by Thomas, *supra*, note 57 at 259 n. 4.

[100] *R.* v. *Hill*, [1963] Crim. L.R. 525.

[101] *Supra*, note 25 at 333 has raised this problem.

[102] *Id.*

[103] *Id.*

mentally ill. Sometimes such dispositions are rationalized on the basis that simple incarceration, if for a long enough period, may itself bring about the prisoner's rehabilitation. In *Regina* v. *Jones*,[104] for instance, the Ontario Court of Appeal sentenced an accused whom psychiatrists had diagnosed as suffering from a personality disorder to twelve years imprisonment following his conviction on a charge of attempted murder. Arnup, J.A. justified the sentence on the grounds *inter alia* that it might "assist in the rehabilitation of the accused, even though the prognosis for the immediate future is very pessimistic indeed."[105] In a similar vein, the *Model Sentencing Act* prepared by the National Council on Crime and Delinquency (U.S.A.) recommends long sentences for dangerous offenders on the premise that "violent action is a characteristic of the young rather than the old offender."[106] The purpose of a lengthy prison term would be "to continue him until that period of his life when release would be safe and rehabilitation likely."[107] By way of contrast, the Canadian Committee on Corrections were distinctly of the opinion that long term imprisonment militated strongly against rehabilitation. In the Committee's words:

> . . . a person who has received a very long definite sentence, say 20 years, may in fact be more dangerous at the expiration of his sentence and return to freedom than when he was sentenced.[108]

This argument would seem to strike also at what is perhaps the chief justification of long term imprisonment, namely, the protection of the public. Yet judges frequently impose the maximum penalties prescribed for protective purposes, and it is not surprising that mentally abnormal offenders who are considered to be incurable rank as prime candidates for this form of sentencing.[109] A recent example of such an occurance is the Ontario Court of Appeal's decision in *Regina* v. *Fisher*.[110] In that case the accused, who was a reformatory inmate, had been convicted of beating up and stabbing a guard while escaping from that institution. He received from the trial court consecutive sentences of one and two years imprisonment on the escape custody and wounding charges respectively. These were to be added onto the term he was currently serving. On appeal by the Crown against sentence, however, a psychiatric report was ordered. It revealed that Fisher was a psychopathic personality who had spent most of his life behind bars — including a twenty-year stint at Penetang's centre for the criminally insane. Quite understandably, Fisher was said to be incurable and assessed as unsuitable for further psychiatric treatment. On these facts, the sentence on the wounding charge was

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[104] [1971] 3 C.C.C. (2d) 153.

[105] *Id.* at 161.

[106] Commentary to section 5 of the *Model Sentencing Act*. And see, Halleck, *supra*, note 36, who has noted (at 285) that "the aging process in itself probably has more to do with reformation than all our correctional endeavours combined."

[107] Commentary to section 5 of the Act.

[108] *Report of the Canadian Committee on Corrections (Ouimet Report)* (Ottawa: Queen's Printer, 1969) at 262.

[109] See, *R.* v. *Aaorns*, [1964] Crim. L.R. 484 and *R.* v. *Saunders*, [1965] Crim. L.R. 250, where the offender's apparent incurability was in each case a factor influencing the Court to impose life imprisonment.

[110] (1975), 17 Crim. L.Q. 246.

raised to the maximum of fourteen years. What is interesting is that Houlden, J.A. remarked in the course of his judgment that had it not been for the accused's mental disorder, he would only have increased the sentence by three years.

If it is true that imprisonment makes offenders more dangerous than they were before being sentenced, it would seem that total protection of the public can only be achieved by imposing sentences which allow for the unfortunate effects that imprisonment has upon offenders. Psychotherapy not being an option in the case of incurable psychopaths, we are left with the alternative of permanent imprisonment.[111] In the *Fisher* case this would only have been possible through the subsequent certification of the accused or through his being designated an habitual criminal in accordance with the procedure set forth in sections 688 and 690 of the Code. Where the courts have had the option of sentencing an incurable psychopath to life imprisonment, they have seized the opportunity in the name of public protection. In *R.* v. *Head*,[112] for example, the Saskatchewan Court of Appeal dismissed the appeal of an accused who had been sentenced to a life term for raping a six-year-old girl. Considering the available psychiatric evidence and the fact that he had previously been convicted of indecent assault on a young girl, the Court felt that rehabilitation was beyond question and that the public could only be safeguarded by depriving the accused of his freedom permanently, or at least indefinitely.

Rehabilitation, incurability, and dangerousness are not the only criteria upon which the courts have grounded their decisions to imprison mentally abnormal offenders. A very popular alternative consideration is that of general deterrence. This fact is quite surprising, not just in view of the widespread disillusionment which the very concept of general deterrence has encountered in recent years,[113] but because one would have thought it especially difficult to deter irrationally motivated behaviour. Nevertheless, judges commonly invoke the principle, seeing nothing peculiar in the deterrence of symptoms of what they themselves view as an 'illness'.

Judicial reliance on the principle of general deterrence can be seen in a great many Canadian criminal cases which involve disordered offenders. *R.* v. *Jones*[114] involved an accused who was convicted on three charges of indecently assaulting young girls and was originally fined a total of $450. Psychiatric evidence showed that he suffered from "sexual repression" but that there was little likelihood of his committing further such offences. Despite the fact that the reporting psychiatrist had warned that imprisonment would only worsen the accused's condition, the Ontario Court of Appeal substituted

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[111] Conversely, sentences of life imprisonment have on occasion been varied to long fixed terms where the offender has been assessed as treatable on the grounds that the indeterminate nature of the life sentence impeded rehabilitation. See, *R.* v. *Donnelly* (1968), 52 Cr. App. R. 731.

[112] [1971] 1 C.C.C. (2d) 436.

[113] See, generally, Gardiner, *The Purposes of Criminal Punishment* (1958), 21 Mod. L. Rev. 117 at 121-25; Walker, *supra*, note 12 at 77-97; Wooton, *Crime and the Criminal Law* (London: Stevens, 1963) at 97-101.

[114] (1956), 115 C.C.C. 273 (Ont. C.A.).

a prison term of six months definite and twelve months indeterminate on each count, the sentences to be served concurrently. The reasoning of the majority[115] was expressed by Pickup, C.J.O. who said:

> It may be that this particular respondent, after continuation of psychiatric treatment, will not repeat the offence and there is a possibility of his being cured of his condition by such psychiatric treatment, but these are matters of grave uncertainty. I think I would agree that, so far as the condition of this particular respondent is concerned, a prison term may be detrimental to his recovery, but in my opinion the offence is too serious for punishment by a fine or by suspending sentence and placing the respondent upon probation. It is said that the prison term will not have any deterrent effect upon other persons who are truly sex perverts. That may be so, but I do not think it justifies disregarding the deterrent effect upon those persons whom sentence will deter and who might be disposed to commit an assault of this character.[116]

With respect it seems unclear from this reasoning exactly whom the learned Chief Justice sought to deter. Surely anyone who indecently assaults young children can be fairly regarded as a "sex pervert".[117] Yet the learned judge admitted that those persons who were "truly sex perverts" would probably not be deterred. Are we to assume that the sentence was aimed only at deterring *amateur* sex perverts? Or at deterring normal individuals *masquerading* as sex perverts?

Laidlaw, J.A. rejected the views of Pickup, C.J.O. on the issue of general deterrence. In a dissenting judgment he said:

> Then would a term of imprisonment imposed on the respondent in the unusual circumstances of this case deter others from committing criminal acts of sexual misbehaviour? In my opinion it would not. Certainly it would not restrain others who suffer from mental maladjustments or illness of a kind that makes them unable to resist the driving and overpowering sexual impulse to do a wrongful act.[118]

The Ontario Court of Appeal again adopted the theme of general deterrence in the case of *Regina* v. *Doucet*.[119] That case involved an appellant who was convicted of indecently assaulting a young boy and who had received from the trial court a sentence of imprisonment for two years less a day definite and two years less a day indeterminate. This sentence was affirmed on appeal, the majority of the court apparently relying (as had the trial judge) upon the opinion of a psychiatrist that a term of imprisonment would deter not only the accused but other pedophiles as well from the practice of their perversion. Brooks, J.A. dissented, however, on the grounds that the doctor's evidence had been misconstrued, and that the goal of rehabilitation outweighed that of deterrence. He felt probation with psychiatric treatment was a more suitable sentence in the circumstances.

Once again the goal of general deterrence motivated the Ontario Court

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[115] Aylesworth, Chevrier and Schroeder, JJ.A. concurring.

[116] *Supra*, note 114 at 275.

[117] A possible exception may be made in the case of mental defectives. See *R.* v. *Pascoe* (1974), 17 Crim. L.Q. 142 where a mentally defective male was sentenced to twelve months definite and twelve months indefinite for attempting to indecently assault a seven-year-old boy.

[118] *Supra*, note 114 at 280.

[119] [1971] 1 O.R. 705.

of Appeal in *R.* v. *Murphy*.[120] In that case the accused had been convicted on two charges of rape and one charge of attempted rape. He was sentenced to imprisonment for a total of two years less a day definite and two years less a day indeterminate plus three years probation. On appeal by the Crown, however, the sentences were raised to a total of seven years imprisonment. Of interest is the fact that the psychiatric report indicated that the accused had responded well to treatment and was no longer dangerous to others. Furthermore it suggested that a long stay in prison would impede his total recovery. Nevertheless the court expressed its view that the original sentences were inadequate in that they failed to sufficiently take into account the aspect of deterrence to others.[121]

(b) *With a recommendation for treatment*

Where an offender has been assessed as both dangerous to the public and in need of psychiatric treatment, Canadian Courts have traditionally given precedence to the need for public protection and treated the accused's mental rehabilitation as a matter of secondary concern. While the priorities here seem faultless they are, paradoxically, of no help whatsoever in determining the appropriate disposition for disordered offenders who have not committed offences demanding life imprisonment on tariff principles alone. Illustrative of this problem is the case of *Regina* v. *Wallace*,[122] an instance where the Ontario Court of Appeal was called upon to assess the correctness of a ten year sentence imposed on a paranoid schizophrenic for the offences of robbery and assault. Acknowledging the fact that the accused's amenability to treatment would decrease with the amount of time spent in prison, Brooke, J.A. pondered:

> If the primary object of the criminal law is the protection of society, how apt is this sentence? Perhaps such a sentence as this one offers immediate protection to society but it clearly does little to protect it for the future.[123]

In these circumstances the accused's mental condition was considered as a factor which could reduce the term of imprisonment from that which might normally have been imposed. Substituting a sentence of four years for the original ten, Brooke, J.A. said:

> It is plain that a sentence the length of that imposed was very much more severe punishment for this man than for a normal person, because of the terror he experiences, the danger of self-destruction[124] and the loss of amenability to treat-

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[120] (1972), 15 Crim. L.Q. 13.

[121] See, also, *R.* v. *Gunnell* (1966), 50 Cr. App. R. 242 at 245-46 where the trial judge refused to issue a hospital order and sentenced the accused to life imprisonment instead saying:

> . . . crimes of this kind . . . must . . . be dealt with in such a way as to make plain that the law is concerned and ever will be concerned to protect people who suffer as you caused those women to suffer by these quite appalling sexual attacks that you made upon them. Punishment must be an element in this case, and that punishment can only be achieved by imprisonment.

[122] (1973), 11 C.C.C. (2d) 95.

[123] *Id.* at 100.

[124] For an interesting discussion concerning the risk of mentally abnormal offenders committing suicide see Blair, *Life Sentence then Suicide* (1971), 11 Med. Sci. and the Law 162.

> ment. . . . The best future protection for society lies in imposing a sentence which will make the appellant's rehabilitation probable.[125]

Surprisingly few Canadian courts have recognized the dilemma articulated by Brooke, J.A. In certain cases this fact is no doubt attributable to the nature of mental disorder and type of offence concerned. Where, for example, the accused is considered incurably deranged and has been convicted of an offence punishable by life imprisonment, there is no compunction about imposing the maximum sentence. In *Regina* v. *Hill*[126] Jessup, J.A. reasoned that:

> When an accused has been convicted of a serious crime in itself calling for a substantial sentence and when he suffers from some mental or personality disorder rendering him a danger to the community but not subjecting him to confinement in a mental institution and when it is uncertain when, if ever, the accused will be cured of his affliction, in my opinion the appropriate sentence is one of life. Such a sentence, in such circumstances, amounts to an indefinite sentence under which the parole board can release him to the community when it is satisfied, upon adequate psychiatric examination, it is in the interest of the accused and the community for him to return to society.[127]

Once a court has imposed a sentence of life imprisonment it has effectively extinguished any dependency of public safety upon the rehabilitation of the offender. If oriented toward reform, however, the court may choose to deal with the matter by a simple recommendation that the accused receive whatever psychiatric help may be available to him while in prison. Thus in *Hill* Jessup, J.A. said:

> I would strongly recommend that the appellant receive psychiatric treatment and I would request the Crown to forward a copy of this judgment to the Solicitor-General and to the penitentiary authorities.[128]

Similarly, in *Regina* v. *Leech*[129] the Alberta Supreme Court said:

> Whilst under sentence the accused, though not legally insane, should be considered as a suitable patient for psychiatric care.[130]

Because the psychiatric facilities in Canadian prisons are notoriously inadequate,[131] some judges may feel obligated to recommend that the offender be transferred under section 19 of the *Penitentiary Act*[132] to a provincial

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[125] *Supra*, note 122 at 100.

[126] (1974), 15 C.C.C. (2d) 145.

[127] *Id.* at 147-48. The rule here was followed in *Regina* v. *Haig* (1974), 26 C.R.N.S. 247 (Ont. C.A.). The reasoning is similar to that of the English Court of Criminal Appeal in *R.* v. *Hodgson* (1967), 52 Cr. App. R. 113.

[128] *Supra*, note 126 at 148.

[129] [1973] 1 W.W.R. 744.

[130] *Id.* at 756.

[131] In 1969 the Ouimet Committee reported (*supra*, note 108 at 237) that "the cross-Canada picture indicates that most psychiatric services within correctional systems are minimal and leave much to be desired."

[132] R.S.C. 1970, c. P-6:

> 19(1) The Minister may, with the approval of the Governor in Council, enter into an agreement with the government of any province to provide for the custody, in a mental hospital or other appropriate institution operated by the province, of persons who, having been sentenced or committed to a penitentiary, are found to be mentally ill or mentally defective at any time during confinement in penitentiary.

mental hospital outside the prison itself. In *Regina* v. *Robinson*[133] the Ontario Court of Appeal imposed a sentence of eight years imprisonment "for the express purpose that this man receive at once such treatment as may be available to him at Penetang or such other hospital for treating persons with mental disorders as may be available."[134] The problem with this recommendation, as with the others cited, is that it is not in any way binding upon the penitentiary authorities. It therefore offers no assurance that the offender will receive treatment. As the Law Reform Commission has pointed out in a recent working paper:

> Sometimes such recommendations are followed, often they are not. Although it is theoretically possible for prison authorities to transfer mentally disordered offenders to mental hospitals, in practice such transfers are rare. Because of the sparse facilities for psychiatric treatment in prisons generally, many prisoners suffering from serious mental disorders are detained without the prospect of treatment.[135]

When a disordered offender is convicted of an offence not punishable by life imprisonment his abnormality may modify the court's application of normal tariff principles.[136] In *Regina* v. *Fisher*, for instance, the court considered mental abnormality a factor which could quite properly *increase* a sentence's duration from that which the offence's severity alone would have rated. It should be noted, however, that public safety was the premise upon which this decision rested. Where sentences are geared toward rehabilitation, a popular proposition is that expressed by Norval Morris:

> . . . power over a criminal's life should not be taken in excess of that which would be taken were his reform not considered as one of our purposes.[137]

As Morris has himself pointed out,[138] subscription to this philosophy is by no means universal. Kadish has, for instance, asked:

> Why should the rehabilitative purpose be subordinated to the deterrent, vindicatory and incapacitative purposes?[139]

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[133] (1974), 19 C.C.C. (2d) 193.

[134] *Id.* at 198-99. Likewise in *Regina* v. *Bradbury* (1973), 23 C.R.N.S. 293 (Ont. C.A.) at 298 the Court said:

> In dismissing the appeal, the members of this Court wish to bring to the attention of the penitentiary authorities the repeated statements emanating from the Mental Health Centre at Penetanguishene that Bradbury requires long-term treatment in a controlled setting such as can be provided by the Mental Health Centre and that the Mental Health Centre is prepared to accept him for treatment.

[135] Law Reform Commission of Canada, *Working Paper: The Criminal Process and Mental Disorder* (Ottawa: Information Canada, 1975) at 46.

[136] *Supra*, note 51 at 272.

[137] Morris and Howard, *Studies in Criminal Law* (Oxford: Clarendon, 1964) at 175.

[138] Morris, *The Future of Imprisonment* (Chicago: University of Chicago Press, 1974) at 18.

[139] Review of Morris and Howard, *Studies in Criminal Law*, (1965) 78 Harv.L.Rev. 907 at 908. A staunch believer in the primacy of rehabilitation is A. A. Bartholomew. He has complained, *supra*, note 34 at 336, that:

> It is almost impossible to undertake psychotherapy with a man on a fixed 'tariff' sentence: apart from the rigidity of a fixed sentence, the tariff invariably is inappropriate to the particular man and his needs. Would anyone expect to be admitted to, say, the surgical ward of a hospital for a fixed period; the period being decided upon in terms of the 'commonest time'?

Furthermore, if one accepts, as did Brooke, J.A. in *Wallace*, that the rehabilitation of dangerous offenders and the protection of society are inseparable goals, one may justify the lengthening of sentences for rehabilitative purposes by applying the reasoning used in *Regina* v. *Fisher*. Indeed, this is what seems to have been done in *Regina* v. *Bradbury*.[140] There the trial judge imposed the maximum sentence of fourteen years imprisonment on a charge of wounding where the accused had been diagnosed as suffering from a "character disorder". Reliance was apparently placed on the opinion of the reporting psychiatrist that a very lengthy period of treatment would be necessary before the accused ceased to be dangerous to others. In dismissing the accused's appeal against sentence the Ontario Court of Appeal held that in addition to the nature of the offence, the "urgent need for a protracted period of treatment"[141] and "the need for protection of the public"[142] justified the sentence.

In actual practice, therefore, it seems that Morris' proposition has been rather loosely adhered to. In its strictest sense, it suggests that the rehabilitative ideal (though it might give rise to a recommendation for curative therapy) should play no part whatsoever in determining the length of sentence to be imposed. But as *Bradbury* suggests, the courts have apparently adopted a more flexible rule. If indeed a governing formula is to be found, perhaps it is that put forward by the English Court of Appeal in *R.* v. *Moylan*[143] where it said:

> . . . the court must first determine what are the limits of a proper sentence in respect of the offences charged. Within those limits it may be perfectly proper to increase the sentence in order to enable a cure to be undertaken whilst the prisoner is in prison. But on the authority of *Ford* (*supra*) it is clear that it is not correct to increase the sentence above that within the appropriate range for the offence itself merely in order to provide an opportunity for cure.[144]

The Court further stated that it would not consider itself bound by this rule in cases where the protection of the public was involved. Also worth noting is the decision of the same court in *R.* v. *Turner*[145] where an exception was made to the general rule that the effect of remission must be disregarded when calculating the correct length of sentence. It was reasoned that:

> . . . when one is considering not punishment but considering reform or mental treatment, something which is in the interests of the prisoner, it would be obviously right for this court to take remission into consideration.[146]

4. *Hospital Orders?*

In determining the length of imprisonment to which a disordered offender should be sentenced, many judges find it virtually impossible to ignore the recommendations made in psychiatric reports. As a result, those judges who are truly reform orientated find a way of scaling their sentences to the length prescribed for treatment purposes, while at the same time paying lip service to

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140 (1973), 23 C.R.N.S. 293.

141 *Id.* at 297.

142 *Id.*

143 (1969), 53 Cr. App. R. 590.

144 *Id.* at 594.

145 (1967), 51 Cr. App. R. 72.

146 *Id.* at 73.

Professor Morris' rule. A dramatic example of this tactic in operation may be seen in the recent case of *Regina* v. *Boomhower*.[147] There an offender who had been convicted of discharging a fire-arm with intent to endanger life was remanded to the Penetanguishene Mental Health Centre for pre-sentence examination. Upon receiving evidence that the offender suffered from a personality disorder which would require up to five years of intensive psychotherapy, the trial judge imposed a sentence of seven years imprisonment. The offender was thereafter certified under *The Mental Health Act*. On appeal against this sentence, Martin, J.A. of the Ontario Court of Appeal acknowledged that the learned trial judge had no doubt arranged for the accused's indefinite certification, yet dismissed the appeal on the following grounds:

> In our view the learned trial judge went to great pains to deal with this youthful appellant in a very positive and enlightened manner designed to correct the personality disorder from which he suffers and thereby offer the best long term protection to the public. At the same time the sentence which he imposed upon the appellant does not exceed what is an appropriate sentence in this case, having regard to the very serious nature of the offence committed, apart altogether from the appellant's need for treatment.[148]

The reasoning here demonstrates some pretty fancy footwork on the part of Martin, J.A. While the seven year term (technically the only sentence imposed) may well have been justified by the gravity of the offence alone, it is clear that trial court took power over the offender's life "in excess of that which would [have been] taken were his reform not considered."

Under the English system of hospital orders an express statutory authority is provided whereby courts may accomplish, in a less make-shift fashion, the ends sought in *Boomhower*. Section 60(1) of that country's *Mental Health Act*, 1959[149] enables judges to order a mentally disordered offender's admission to and detention in a hospital. This power is exercisable over persons convicted of offences other than those for which a penalty is fixed by law; or, in the case of magistrates' courts, over persons convicted of summary conviction offences punishable with imprisonment. The authorization of all hospital orders is conditional upon the following criteria being met.

> (a) the court is satisfied, on the written or oral evidence of two medical practitioners . . .
> (i) that the offender is suffering from mental illness, psychopathic disorder, subnormality or severe subnormality; and
> (ii) that the mental disorder is of a nature or degree which warrants the detention of a patient in a hospital for medical treatment. . . .; and
> (b) the court is of the opinion, having regard to all the circumstances including the nature of the offence and the character and the antecedents 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 means of an order under this section.

Section 60(2) of the Act further allows magistrates' courts to make hospital orders without first convicting accused persons if satisfied both that they suffer from mental illness or severe abnormality and that they are in fact guilty of the offences with which they have been charged.

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[147] (1975), 20 C.C.C. (2d) 89 (Ont. C.A.).

[148] *Id.* at 93.

[149] 7 & 8 Eliz., 2, c. 72.

A key feature of the English hospital order is that it may not be combined with any other sentence, such as a fixed term of imprisonment. It does not run for any specified period and, although it lapses automatically at the end of twelve months, it may be renewed indefinitely. Furthermore, it may be coupled with a restriction order preventing the patient from being discharged without the permission of the Home Secretary. In proposing what it has called a system of "hospital permits", the Canadian Committee on Corrections has expressly rejected these elements of the English model As its name suggests, the permit system places the final power over the patient-prisoner in the hands of the hospital rather than the court. In the words of the Committee:

> It was felt that hospital officials should be able to determine who, based upon appropriate admission criteria, would be admitted to and discharged from psychiatric facilities. . . . Where it is indicated that an offender would benefit from treatment in a psychiatric facility, the court should be empowered to authorize placement of the individual in such a facility. This placement should be conditional upon the circumstances being such that his eligibility otherwise met the terms of the mental health legislation in the particular province involved.[150]

Preferring that the permits be combined with relatively short sentences of imprisonment, the Committee has recommended that the period of hospitalization not exceed the length of sentence unless the patient-prisoner is continued as an involuntary patient under provincial mental health legislation.

If adopted, the Committee's permit proposal would do little other than to add a Parliamentary blessing to what may currently be achieved in an unofficial manner. Indeed, the Court in *Boomhower* remarked that:

> . . . the learned trial judge has utilized existing provincial mental health legislation and facilities, and arrangements made between the provincial mental health authority and the penitentiary services to achieve a result similar to that envisaged by the system of hospital permits recommended by the Report of the Canadian Committee on Corrections.[151]

D. CONCLUSION

The principle that "like cases should be treated alike" would seem to be nothing more than an empty platitude in the case of mentally disordered offenders.[152] A survey of recent Canadian decisions reveals marked disparities

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[150] *Supra*, note 108 at 235.

[151] *Supra*, note 147 at 93. The fact that this result can be achieved is apparently not known to all judges, however. In *Regina* v. *Robinson* (1975), 19 C.C.C. (2d) 193 at 198 Brooke, J.A., of the Ontario Court of Appeal, expressed his opinion that the inadequacy of a recommendation that the offender be transferred from prison to a mental hospital "points up the importance of the Committee's recommendation that hospital permits ought to be available". In the case of *R.* v. *H.*, reported in the *Toronto Telegram* on September 20, 1962, the judge "bemoaned the fact that there are no laws which would allow him to send the boy to a centre for psychiatric treatment, but said he would recommend that H get the treatment he needs." Commenting on this case, Swadron, in his book *Detention of the Mentally Disordered* (Toronto: Butterworths, 1964) at 418 has asserted: "The most a sentencing Court can do in Canada under the present law is recommend that the prisoner receive psychiatric treatment."

[152] This may indeed be the case with all types of offenders. See the studies cited by Hood and Sparks, *Key Issues in Criminology* (New York: McGraw-Hill, 1970) at 141-70.

between the sentences imposed on persons who have committed the same crimes and who apparently suffer from the same disorders. As demonstrated by the *Jones*[153] and *Allen*[154] cases, a pedophile convicted of indecent assault may on his first offence receive a suspended sentence with probation or, alternatively, a term of imprisonment, depending on the trial judge he has drawn.[155] A homosexual convicted of gross indecency may be fined as in *R.* v. *Five Accused Persons*[156] and *Boisvert and Lupien*;[157] may be placed on probation with psychiatric treatment as in *Holte and Landry*,[158] *La Chance and Bliss*,[159] *Desjarlais and Ferguson*,[160] and *Hermann and Singer*;[161] or may be imprisoned as in *Marshall*,[162] *Turpin*,[163] and *DeSeve*.[164] A psychopath sentenced to life imprisonment may be recommended for transfer to a mental hospital as in *Robinson*[165] or *Bradbury*,[166] or he may be considered beyond salvation as in *R.* v. *Head*.[167]

It is obvious that not all judges rely upon psychiatry as an aid to sentencing. In studying the frequency with which psychiatric reports were used by Ontario magistrates, Hogarth found that such information was requested in only 4.3 per cent of the cases sampled.[168] Though one would have thought this figure to correspond roughly with the number of offenders perceived as mentally abnormal, it was discovered that a great many magistrates refrained as a matter of policy from seeking psychiatric information even where evidence of mental disorder existed.[169] Still, it would appear that most sentencing judges who suspect mental disorder do request psychiatric reports.[170] As the case of *Jones* and *Murphy*[171] indicate, however, the information contained in such reports may not always influence the judge in determining sentence. Even where it is relied upon, the result may be the imposition of sentences which involve no element of psychiatric therapy whatsoever.[172]

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153 *Supra*, note 104.

154 *Supra*, note 92.

155 The *Jones* and *Allen* cases have been compared by Jaffary, *Sentencing of Adults in Canada* (Toronto: University of Toronto Press, 1963) at 21-22.

156 *Supra*, note 58.

157 *Supra*, note 60.

158 *Supra*, note 73.

159 *Supra*, note 74.

160 *Supra*, note 75.

161 *Supra*, note 76.

162 Unreported, but cited by Sanders, *supra*, note 73 at 27.

163 *Id.*

164 *Id.* at 28.

165 *Supra*, note 133.

166 *Supra*, note 134.

167 *Supra*, note 112.

168 *Supra*, note 13 at 240.

169 *Id.* at 238.

170 *Id.*

171 *Supra*, notes 114 and 120.

172 See, *Fisher*, *supra*, note 110 and *Doucet*, *supra*, note 119.

In all probability, those judges who do in fact impose psychotherapeutic sentences act on the basis of certain fundamental assumptions about mental disorder and psychiatry. The first is that the accused suffers from a mental "illness" which is capable of being "diagnosed". In this regard it must be stated that the reliability of modern psychiatric diagnoses is a matter of considerable controversy. While sceptics have attacked them for their "gross unreliability",[173] zealots have hailed them as being "as accurate as those in tuberculoses, communicable disease, or other illness."[174] With respect, this latter view seems the less plausible of the two. The fact that psychiatrists frequently disagree in their clinical judgments is one well known to members of that profession and to lawyers and judges as well.[175] The reason for this lack of consensus is not entirely clear. Of the several possible explanations which have been offered, one is the existence of the various schools of thought which have developed in the field;[176] divergent clinical judgments may be the result of differing theoretical bases. Another explanation is the susceptibility of each doctor's observations to subjective coloration;[177] individual personalities and experiental backgrounds may account for differences in diagnosis even amongst members of the same school of thought. Perhaps the most compelling explanation is that offered by Thomas Szasz, namely, that there is in fact no such thing as mental illness to begin with. How can anyone diagnose a disease which does not exist? Szasz's theory is simply that:

> Strictly speaking . . . disease or illness can affect only the body. Hence, there can be no such thing as mental illness. The term 'mental illness' is a metaphor.[178]

But even the non-existence of mental illness should not in itself remove

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[173] Hakeem, *A Critique of the Psychiatric Approach to Crime and Correction* (1958), 23 Law and Contemp. Problems 650 at 666.

[174] Bennett, Hargrove and Engle, *The Practice of Psychiatry in General Hospitals* (1956) at 91, quoted by Hakeem, *id.* at 662.

[175] See, Hakeem, *supra*, note 173 at 660-68; Campbell, *Sentencing: The Use of Psychiatric Information and Presentence Reports* (1972), 60 Ky. L. J. 285 at 313-15; and Beck, *Reliability of Psychiatric Diagnosis: A Study of Consistency of Clinical Judgments and Ratings* (1962), 119 Am. J. Psychiatry 351 where psychiatrists who participated in a study were found to be unanimous in their diagnoses only slightly more than half of the time. But see, Overholser, *The Psychiatrist and the Law* (1953) at 23, quoted by Hakeem, *supra*, note 173 at 662, where it is asserted that

> There is general agreement among psychiatrists upon the essential facts and the significance of words and actions, although there are minor differences in theory. The differences and disagreements are much exaggerated by the critics, and constitute one of the alleged reasons for the reluctance of the legal profession to accept any more readily than they do psychiatric concepts and teachings.

[176] *Supra*, note 27 at 244. But see, Watson, "Untying the Knots: The Cross-Examination of the Psychiatric Expert Witness" in Sugarman, *Examining the Medical Expert* (Ann Arbor: Mich. Institute of Continuing Legal Education, 1969) at 16, where the author has stated that since today's psychiatric theories are all genetic in concept, the differences between Freudian and Jungian background are really inconsequential.

[177] Diamond and Louisell, *The Psychiatrist as an Expert Witness: Some Ruminations and Speculations* (1965), 63 Mich. L.Rev. 1335 at 1341.

[178] *Supra*, note 11 at ix. The author asserts (at 37) that even organic illnesses which are said to affect the mind are not mental illnesses. Rather, they fall into the class of "bodily diseases which, by impairing the functioning of the human body as a machine, create difficulties in social adaptation."

an offender from the ambit of psychiatric intervention. Although few would disagree as to psychiatry's ability to alter human behavior, a more important question is whether psychiatry can alter behaviour for the better (*i.e.*, affect a "cure" for the alleged illness). This brings us to our second assumption, namely, that psychiatry can in fact do just that. As Nigel Walker has noted,[179] the effectiveness of present day psychotherapeutic techniques is a hotly debated issue. Halleck, among others, has observed that "in spite of the enormous effort that has gone into treatment of the mentally ill, there is no scientific proof of the effectiveness of psychotherapy."[180] Ardent anti-psychotherapists such H. J. Eysenck have cited studies indicating that persons suffering from certain disorders are as likely to recover spontaneously as be cured by psychotherapy.[181] Halleck has questioned the significance of such findings, however, by pointing out that terms such as "cure" and "psychotherapy" are ambiguous and hard to define. He has written:

> The problem with evaluating psychotherapy in the correctional setting is not only a lack of precision in defining what changes we are looking for but also an unjustified carelessness in deciding what is to be called psychotherapy. There is an unfortunate tendency to label any conversation which takes place between a professional and an offender as psychotherapy. We can hardly expect the offender who receives five to fifty hours of therapy with an untrained psychiatric resident or social worker to respond in the same way as a wealthy neurotic who receives 500 to a thousand hours of therapy from a highly skilled psychoanalyst.[182]

Although he has not cited the evidence being relied upon, Walker has concluded that "there is still more support for the claim that [psychotherapy] is effective"[183] in the treatment of certain mental disorders. In all likelihood, those judges who impose sentences which involve psychotherapy subscribe to this view.

Implicit as well in the psychotherapeutic sentence is another very crucial assumption: that the enforced treatment of mental disorder is morally and ethically sound. Once again, however, the consensus on this point is far from unanimous. Opinions range from complete endorsement of the coerced cure (with apparent disregard for the nature of the offence involved[184]) to utter rejection of all non-contractual psychotherapy.[185] Although the psychiatric treatment of probationers needn't necessarily violate the doctrine of voluntary informed consent,[186] it has been suggested that the same cannot be said with regard to prison inmates.[187] In *Kaimowitz et al.* v. *Department of Mental Health (Mich.)*[188] the Wayne County Circuit Court was of the opinion

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[179] *Supra*, note 12 at 111.

[180] *Supra*, note 36 at 338.

[181] Eysenck, *Crime and Personality* (London: Paladin, 1970) at 151-52.

[182] *Supra*, note 36 at 339.

[183] *Supra*, note 12 at 111.

[184] *Supra*, note 80.

[185] See, generally, Szasz, *The Manufacture of Madness* (New York: Dell, 1970).

[186] *Supra*, note 87.

[187] See, Burt, *Biotechnology and Anti-Social Conduct: Controlling the Controllers* (1974), Ohio State Law Forum Lectures 1, referred to by Morris, *supra*, note 37 at 25.

[188] *Supra*, note 84 at 25.

that the incarcerated offender was "particularly vulnerable as the result of his mental condition, ... involuntary confinement, and the effect of the phenomenon of 'institutionalization'." Nevertheless, Morris has stated:

> I adhere to the view that it is possible to protect the inmates' freedom to consent or not; that we must be highly sceptical of consent in captivity, particularly to any risky and not well-established procedures; but there seems little value in arbitrarily excluding all prisoners from any treatment.[189]

What then is the proper role for the psychiatrist in the sentencing process? While some commentators subscribe to the view that "it is in recommending disposition where the psychiatrist ... can most helpfully assist the court",[190] others have concluded that psychiatric evidence should not be admissible in court.[191] Although the radical nature (and questionable wisdom) of this suggestion makes its implementation unlikely within the near future, it is submitted that for the present psychiatric power must at least be limited in a number of ways. Furthermore, the judge who wishes to impose a psychotherapeutic sentence should be restricted by certain minimum rules of conduct. With these purposes in mind, the following recommendations are offered. They are not intended as a comprehensive guide to the sentencing of mentally disordered offenders, but merely represent a skelton list of suggestions which come to mind as a direct result of the preceding discussion. Only recommendations 1 and 9 would seem susceptible of legislative implimentation. The rest must remain as formulations of suggested policy.

1) SECTIONS 543(2), 543(2.1) AND 608.2 OF THE *CRIMINAL CODE* SHOULD BE REPEALED. IN THEIR PLACE THE FOLLOWING REMAND PROVISION SHOULD BE SUBSTITUTED:[192]

> (1) A court judge or magistrate may, when of the opinion, supported by the evidence or, where the prosecutor and the accused consent, by the report in writing of at least one duly quailfied medical practitioner, that there is reason to believe that a person who appears before him charged with or convicted of an offence, suffers from mental disorder, remand the person, by order in writing, to a psychiatric facility for examination for a period not exceeding thirty days.
>
> (2) The term "mental disorder", when used in this section, means any organic disease which affects the brain or any mental disability.
>
> (3) Each of the following, and *only* the following, shall be deemed to constitute sufficient reason to believe that the person being remanded for psychiatric examination "suffers from mental disorder" within the meaning of subsection (1):
>
> (a) the person has been charged with or convicted of an offence involving serious violence against a member or members of his own family;
>
> (b) the person has been charged with or convicted of an offence under sections 143, 145, 148, 149, 150, 153, 155 or 157;
>
> (c) the person has been charged with or convicted of an offence the commission of which exhibited a bizarre or irrational quality;

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189 *Supra*, note 37 at 25.

190 Slovenko, *Psychiatry, Criminal Law, and the Role of the Psychiatrist* (1963), Duke L. J. 395 at 407.

191 Hakeem, *supra*, note 173 at 681.

192 Because the sections named apply to remands before verdict as well as before sentence, the wording of the recommended provision allows for the provision's application in identical circumstances.

(d) the person has exhibited a bizarre or irrational manner of behaviour in the courtroom;

(e) the person is one for whom there exists another compelling reason (other than those specified in subparagraphs (a) to (d)) for believing that he suffers from mental disorder.

(4) Notwithstanding subsection (3) where a person is remanded under this section the court judge or magistrate shall, in the order in writing referred to in subsection (1) specify in detail the circumstances which prompted him to remand the person for psychiatric examination.

(5) Where the person being remanded for psychiatric examination under this section has not been taken into custody or has been released by virtue of any provision contained in Part XIV, the court, judge or magistrate shall stipulate in the order in writing referred to in subsection (2) that the accused be examined as an out-patient and that he not be confined against his will in the psychiatric facility for any period of time in excess of that required for actual examination.

(6) A court, judge or magistrate shall not make an order under this section until he ascertains from the senior physician of a psychiatric facility that the services of the psychiatric facility are available to the person to be named in the order.

(7) Where an examination is made under this section, the senior physician of the psychiatric facility shall report in writing to the judge as to the mental condition of the person.

(8) Where a report is filed with the court under subsection (7), the clerk of the court shall forthwith cause a copy of the report to be provided to the accused or his counsel and to the prosecutor.

It should be noted that many of the safeguards contained in this provision could, of course, be circumvented by using the remand provision contained in provincial mental health legislation. This problem can only be solved by repealing provincial remand provisions.

2) PSYCHIATRIC REPORTS SHOULD NOT CONTAIN RECOMMENDATIONS AS TO WHAT SENTENCE SHOULD BE IMPOSED.

Although Bartholomew may have been correct in his assertion[193] that the courts do in fact seek recommendations concerning sentence, such intentions on the part of the judges remain something less than admirable. Szasz has argued that the judges who use psychiatrists in this fashion do so in an attempt to escape responsibility and alleviate their own feelings of guilt.[194] Moreover, the result is to place the psychiatrist in an unduly onerous position; in effect, he becomes the sentencing judge.[195] This status may create additional problems, should the reporting psychiatrist ultimately be the one responsible for the offender's treatment; it is not the ideal basis for a therapeutic relationship.

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[193] *Supra*, note 42.

[194] Szasz, *Some Observations on the Relationship Between Psychiatry and the Law* (1956), 75 A.M.A. Archives of Neurology and Psychiatry 297, cited by Campbell, *supra*, note 175 at 311 n. 150.

[195] *Supra*, note 185 at 56, where Szasz asserts that the mere statement of psychiatric diagnosis is itself a form of sentencing:

> . . . once a person is cast into the role of mental patient, there is a permanent record of his deviance. Like the inquisitor, the psychiatrist can 'sentence' a person to mental illness, but cannot wipe out the stigma he himself has imposed. In psychiatry, moreover, there is no pope to grant absolute pardon from a publicly affirmed diagnosis of mental illness.

3) PSYCHIATRIC REPORTS SHOULD CONFINE THEMSELVES TO DIAGNOSES AND ASSESSMENTS OF TREATABILITY.

Regardless of the dispute concerning reliability of psychiatric diagnoses and effectiveness of psychiatric treatment, these are the only two areas in which psychiatrists claim to have expertise. For this reason, gratuitous opinions on the subjects of non-psychiatric punishment (as opposed to 'punitherapy') and general deterrence (see, *R.* v. *Doucet*)[196] are both valueless and prejudicial.

4) 'DANGEROUSNESS' SHOULD BE REJECTED AS A BASIS FOR IMPOSING SENTENCES OF IMPRISONMENT.

This recommendation is one made by Norval Morris. The concept of dangerousness, he has argued, "presupposes a capacity to predict future criminal behaviour"[197] far beyond the technical ability which anyone (including psychiatrists) presently possesses. Therefore, he has stated:

> The distressing moral problem inherent in this situation can be stated as 'whom shall we trust?' For the time being my reply is 'nobody'. I believe that an effective and just system of criminal justice can be constructed without reliance on *increasing* our power over offenders on the grounds of their predicted dangerousness. Within the ambit of power defined by other purposes (most of them retributive), we must frequently relate sentences and parole decisions to our best judgments of the offender's dangerousness; but we should not rely on such inadequate judgments to raise the maximum of punishment.[198]

5) THE NEED FOR PSYCHIATRIC TREATMENT SHOULD NEVER *INCREASE* THE LENGTH OF SENTENCE FROM THAT WHICH NORMAL TARIFF PRINCIPLES DICTATE.

This, again, is Morris's proposition.[199] Strictly speaking, the length of sentence should be determined entirely independently from considerations concerning the length and type of treatment judged appropriate for the offender's disorder. Once this has been done, the offender's mental state should be considered in mitigation of sentence only.

6) THE EFFECT OF REMISSION SHOULD NEVER BE CONSIDERED WHEN CALCULATING THE CORRECT LENGTH OF SENTENCE.

As the case of *R.* v. *Turner*[200] demonstrates, an exception to the general rule has been made where the offender is considered to be in need of psychiatric treatment. Courts who wish to tailor the length of sentence to correspond to the period prescribed for effective treatment allow for the offender's parole eligibility. The reason offered by the English Court of Appeal for doing this was that psychotherapy was obviously "in the interests of the

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[196] *Supra*, note 48.

[197] *Supra*, note 37 at 62.

[198] Morris, *Psychiatry and the Dangerous Criminal* (1967-68), 41 So. Cal. L. Rev. 514 at 532-3.

[199] *Supra*, note 137.

[200] *Supra*, note 145.

prisoner."[201] With respect, this is insufficient justification. In the words of Thomas Szasz, it "ignores the possibility that the alleged sufferer . . . might prefer to be left alone . . . ."[202] Though no doubt the Court in *Turner* was motivated by the best of intentions, one would be wise to consider Samuel Johnson's warning that "the road to hell is paved with good intentions."[203]

7) WHERE PSYCHOTHERAPY IS CONSIDERED APPROPRIATE, THE TYPE OF TREATMENT EMPLOYED SHOULD BE NO MORE DRASTIC THAN THE SERIOUSNESS OF THE OFFENCE MERITS.

This recommendation is similar to one proposed by Kittrie in his Therapeutic Bill of Rights. In section 8 he has stated that "any compulsory treatment must be the least required reasonably to protect society."[204] It is submitted that this section does not go far enough in safeguarding the disordered offender against disproportionate curative treatment. Under Kittrie's proposal, a relatively innocuous fetishist could be subjected to radical behaviour therapy if that was the only way to protect women from having their panties stolen from their clotheslines. It is contended, however, that prolonged treatment with electroshock, emetics, psychotropic drugs or other aversive stimuli would be too severe a penalty for the crime of petty theft.

Because psychotherapy is often hard to distinguish from punishment, the above recommendation may be thought of as another expression of the principle of "limited retribution". The principle, in Walker's words is that "the unpleasantness of a penal measure must not exceed the limit that is appropriate to the culpability of the offence."[205] The recommendation herein stated may perhaps more accurately be referred to as one of "limited reformation"; it seeks to protect the offender from excessive rehabilitation whether that process be unpleasant or enjoyable.

8) WHERE POSSIBLE, PROBATIONARY PSYCHIATRIC TREATMENT SHOULD BE VOLUNTARY.

Ideally, disordered persons who are placed on probation should be advised to undergo therapy (as in the cases of *Regina* v. *H.*[206] and *Regina* v. *Allen*[207]) rather than having treatment made a formal condition.

9) THE *CRIMINAL CODE* SHOULD BE AMENDED TO PROVIDE FOR A SYSTEM OF HOSPITAL ORDERS.

The provision should look something like this:

(1) Where a person convicted of an offence is sentenced to imprisonment the

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[201] *Id.*

[202] *Supra*, note 185 at 16.

[203] Quoted by Szasz *supra*, note 185 at xviii.

[204] Kittrie, *The Right to be Different* (Baltimore: Pelican, 1973) at 404.

[205] *Supra*, note 12 at 31.

[206] *Supra*, note 91.

[207] *Supra*, note 92.

court shall, upon application, hear evidence as to whether the offender is suitable for a hospital order.

(2) Where the following conditions are satisfied, that is to say —

(a) the court is satisfied, on the written or oral evidence of at least two psychiatrists

(i) that the offender is suffering from mental disorder; and

(ii) that the mental disorder is of a nature or degree which warrants the detention of the offender in a hospital for psychiatric treatment;

(b) the offender has consented in writing to an order under this section;[208] and

(c) an appropriate psychiatric hospital has agreed in writing to accept the offender as a patient;[209]

the court may by order authorize his admission to and detention in such hospital as may be specified in the order.

(3) An order for the admission of an offender to a hospital (herein referred to as a hospital order) shall not be made under this section unless the court is satisfied that arrangements have been made for the admission of the offender to that hospital in the event of such an order being made by the court, and for his admission thereto within a period of twenty-eight days beginning with the date of the making of such an order.

(4) A hospital order shall be sufficient authority —

(a) for a peace officer or any other person directed to do so by the court to convey the patient to the hospital specified in the order within a period of twenty-eight days; and

(b) for the managers of the hospital to admit him at any time within that period and thereafter to detain him in accordance with the provisions of this section.

(5) No person detained in a hospital under the authority of a hospital order shall be discharged or transferred therefrom prior to the expiration of his sentence unless parolled or transferred to a correctional institution in accordance with subsections (8) and (9) of this section.

(6) No person shall be detained in hospital under the authority of a hospital order for a period of time longer than the duration of his sentence.

(7) Nothing in this Part shall be deemed to affect the offender's eligibility for parole.[210]

(8) An offender who has been made the subject of a hospital order may at any time request that the balance of his sentence be served in a correctional institution, in which case effect shall forthwith be given to that request.[211]

(9) A hospital that has agreed to accept the offender as a patient in accordance with subparagraph (2)(c) of this section may, if it considers the offender to be no longer suitable for treatment, request that the balance of the offender's sentence be served in a correctional institution, in which case effect shall forthwith be given to that request.[212]

(10) An offender serving his sentence under a hospital order is deemed to be serving his sentence in prison for the purposes of escapes and being at large without lawful excuse.[213]

(11) A court's decision to impose or not to impose a hospital order may be appealed in the same manner as any other sentence of the court.[214]

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[208] This was suggested by the Law Reform Commission of Canada in its recent working paper, *supra*, note 135 at 47.

[209] *Id.*

[210] *Id.*

[211] *Id.*

[212] *Id.*

[213] *Id.*

[214] *Id.* at 48.

This provision is basically an embodiment of what can already be achieved informally;[215] as mentioned earlier, many judges are either unaware of the possibility of such procedure, or else wary of its propriety. The purpose behind codification would simply be to alert judges that such an alternative exists. The key element of the provision set out above is the consent of the offender (subsection 2(b)). If an offender himself wishes to be hospitalized rather than imprisoned, and the court and psychiatric facility are agreeable, there would seem to be no good reason why he should not be. Unfortunately, the enactment of this provision would not preclude an offender from being involuntarily hospitalized by the informal means discussed earlier. Provincial mental health legislation, unless amended, could still be used as a means of circumvention.

One final word. It is by no means suggested that hospital orders, whether consensual or not, are an effective means of dealing with disordered offenders. From the standpoint of repeated hospitalization and recidivism, the English system has been described as "not spectacularly successful."[216]

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[215] See, generally, text, Part C (4): *Hospital Orders*?

[216] McCabe, Rollin and Walker, *The Offender and the Mental Health Act* (1964), 4 Med. Sci. and the Law 231 at 244.