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PSYCHIATRY AND THE LAW

By R. E. TURNER, M.D.*

Introduction

The purpose of this special issue of the Journal is to highlight the inter-relationship of medicine and law. Psychiatry, as much as any medical specialty, has a most intimate relationship with law, both criminal and civil.

L. Freedman has stated that

> ... at various stages in their historical development psychiatry and law have converged. There are further similarities in the problems with which they are now faced. Neither discipline can therefore be understood without some knowledge of the development and orientations of the other, for their influence is reciprocal and complementary. Both psychiatry and law are concerned with the social deviant, the person who has violated the "rules" of society and whose behaviour presents a problem, not only because his deviance diminishes his ability to function effectively, but because it affects the functioning of the community adversely. Traditionally, the psychiatrists' efforts are directed toward elucidation of the causes and, through prevention and treatment, reduction of the self-destructive elements of harmful beraviour. The lawyer, as the agent of society, is concerned with the fact that the social deviant represents a potential threat to the safety and security of other people in his environment. Both psychiatry and law seek to implement their respective goals through the application of pragmatic techniques, based on empirical observations.[1]

It is the author's intention to historically review some notable developments in the inter-relationship between psychiatry and law, followed by an outline of current law and psychiatry activities, and to complete the paper with an orientation for psychiatry and law to-morrow.

Curran and Partridge defined psychiatry as that branch of medicine whose special province is the study, prevention, and treatment of mental ill-health, however produced.[2] Mayer-Gross, Slater and Roth go further and state that "psychiatry is that branch of medicine in which psychological phenomena are important as causes, signs and symptoms, or as curative agents."[3]

The modern era of the treatment of mental illness dates from the end of the 18th Century, but we must remember that psychiatry existed even at the dawn of civilization.[4] References may be found in Egyptian culture,

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[1] L. Freedman, "Forensic Psychiatry", in Freedman & Kaplan ed., *Comprehensive Textbook of Psychiatry* (Baltimore: The Williams & Wilkins Co., 1967) at 1588.

[2] Curran and Partridge, *Psychological Medicine* (4th ed. Edinburgh and London: E. & S. Livingstone Ltd., 1957) at 1.

[3] Mayer-Gross, Slater and Roth, *Clinical Psychiatry* (3rd ed. by Slater and Roth, London: Bailliere, Tindall & Cassell, 1969) at 6 and 1.

[4] G. Mora, "History of Psychiatry" in A. Freedman and H. Kaplan ed., *Comprehensive Textbook of Psychiatry* (Baltimore: Williams and Wilkins Company, 1967) at 4 - 11, 15.

Assyrian books of dreams, the Hellenistic era, the Old Testament, the Jewish Talmud, Hippocrates, Plato, Aristotle, and the Romans.

The decline of feudal society, religious fervor, witchcraft, and the first indications of social upheaval provided an era in which attitudes to the mentally ill began to change. By the 14th Century, several institutions had already been established for the care or, more accurately, the custody of, mental patients in Metz (1100) Uppsala (1305), Bergamo (1325), and Florence (1385). Gheel became a centre for the care of mental patients during the Middle Ages, and the first mental hospital was founded in Valencia in 1409.

Johann Weyer, born in 1515, has been considered the first "Psychiatrist", for his book on witchcraft and psychotherapy entitled *De Praestigiis Daemonum,* published in Basle in 1563.

Modern medicine and science originated in the seventeenth and eighteenth centuries. A classification of mental disease, the *Praxix Medica,* was published in 1602 by the Swiss physician Platter.

The modern era of treatment of mental illness dates from the end of the 18th Century and may be divided into four periods: (1) the period of humane reform — in France, England, Germany, Italy and Scotland, (2) the introduction of non-restraint — in England and the U.S., (3) the hospital period, and (4) the social and community period.[5]

I. Psychiatry and Law Yesterday

What have been the historical highlights of the inter-relationship between psychiatry and law within the above brief overview of psychiatry itself?

Freedman acknowledges the relationship between psychiatry and law in the sacred writings of the Jews.[6] According to Mora,[7] it is in relation to the legal aspects of mental illness that the Romans made their most important contribution to psychiatry. The *Corpus Juris Civilis* detailed the various conditions which, if present at the time the criminal act was committed, might decrease the "criminal's" responsibility for his actions ... the state of mind of the defendant was determined by a judge; physicians were not consulted in such matters ... those persons who were considered to be mentally ill ... were placed under the custody of relatives or guardians appointed by legal authorities. Laws were passed which defined the ability of the mentally ill to contract marriage, to be divorced by a spouse, to dispose of their possessions, to leave a will, and to testify.

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[5] Henderson and Gillespie's *Textbook of Psychiatry.* Revised by I.R.C. Batchelor (10th ed. London: Oxford University Press, 1969) at 3. The author recommends Chapter 1 in Henderson and Gillespie for an historical review of the modern era at 3-15. This covers the great contributions of Pinel, Esquirol, Tuke, Battie, Rush, Conolly, and others.

[6] *Supra,* note 1 at 1588.

[7] Mora, *supra,* note 4.

Nigel Walker, in his notable contribution on the historical perspective of crime and insanity in England, writes that

> at first sight the most remarkable aspect of this corner of the criminal law is the slowness with which it has developed in the thousand years since the first recorded mention of the insane offender in England. But on reconsideration this becomes less astonishing for several reasons. One of these is, of course, the fact than an essential feature of any legal code, however sophisticated, is its stability ... Innovations must always be suspect, and accepted only when experience has shown that there is a recurring difficulty which can be circumvented in no other way, or only in troublesome ways. Revision may occasionally be dictated by an autocrat (such as Henry VIII) or imposed by the sentiment of the community; but more often than not the pre-existing law eventually reasserts itself, unless the situation recurs with sufficient frequency.[8]

The tenth century laws of Aethelred, which are believed to have been drafted by Archbishop Wulfstan, were intended as a statement of an important general principle:

> ... if it happens that a man commits a misdeed involuntarily, or unintentionally, the case is different from that of one who offends of his own free will, voluntarily and intentionally; and likewise he who is an involuntary agent of his misdeeds should be entitled to clemancy and better terms owing to the fact that he acted as an involuntary agent.[9]

In the *"Laws of Henry I"* which are thought to be statements of customs which survived the Norman Conquest, is the following passage: "If a person be deaf and dumb, so that he cannot put or answer questions, let his father pay his forfeitures. Insane persons and evildoers of a like sort should be guarded and treated leniently by his parents."[10]

Walker is of the opinion that it is uncertain which period evolved the regular practice of acquitting the insane accused instead of leaving him to be pardoned by the king.

> What seems almost certain is that when Bracton compiled his treatise, *On the Laws and Customs of England,* in the middle of the thirteenth century, it was not yet the practice of courts to acquit the insane offender as they later did. Yet Bracton, the first medieval English jurist to deal with the subject, writes as if that is what they should have done. 'Misdeeds are distinguished both by will and by intention ... And then there is what can be said about the child and the madman, for the one is protected by his innocence of design, the other the misfortune of his deed'.[11]

Walker's explanation is that Bracton was not describing procedure but expounding principles. The principle in this case was that intention is all important when it is a question of crime. It is clear that for Bracton, madmen as well as children were examples of offenders who lacked the intention necessary for guilt.

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[8] N. Walker, *Crime and Insanity in England* (Edinburgh: University Press, 1968) at 6, 16, 26.

[9] From Miss A. J. Robertson's translation in her Laws of the Kings of England, VI Aethelred 52 (Cambridge, 1025), in Walker, *supra,* note 8.

[10] See F. Libermann, "Die Gesetze der Angelsachsen", 1 (Halle, 1898), 595 in Walker, *supra,* note 8.

[11] Bracton, "De Legibus et Consvetudinibus Anglize" Woodbine ed. (Yale 1915), Walker, *supra,* note 8.

The first monasteries sheltered the physically ill, the psychically and spiritually possessed, the insane, and the impoverished under the same roof. This failure to differentiate between the various types of social misfits has persisted up to the present.

> One of the first attempts by a physician to influence legal process was the effort of Weyer, in the 16th century to bring the persecution of 'witches' to a halt, clinically observing that this peculiar behaviour reflected the natural processes of disease, rather than supernatural intervention by devilish forces. It should be noted that a century later his clinical demonstrations were declared legally invalid on the grounds that he was a physician rather than a lawyer! During the Age of Enlightenment, the leaders of the Renaissance concerned themselves with the mentally ill and the criminally deviant.[12]

Zacchia (1584 to 1659) is generally regarded as the father of legal medicine. He was called upon frequently by the Pope as his personal physician to provide consultation to the Court of the Sacra Rota. He stated that in his opinion only a physician was competent to judge the mental condition of the person.[13] Zacchia outlines certain "rules" regarding ability to testify, to marry, to enter a religious order, and to leave a will. His importance lies in his liberal philosophy that the person, rather than the law, was to be given primary consideration.

The "Law of the Insane" which established the specific rules, including a mental examination, to be followed in cases of proposed commitment, was passed in England in 1774. In Florence, the Grand Duke began the construction of the hospital Bonifacio under the medical direction of Chiarugi, who specifically stated that "it is a supreme moral duty and medical obligation to respect the insane individual as a person." He later wrote in 1793 to 1794 the three volume work *Medical Treatise on Insanity.*

Four centuries separated Bracton from Hale, who died in 1676. Hale must have been the first, if not the only, Lord Chief Justice of England to interest himself in the psychological theories of his day.[14] He deals with mental disorder in Chapter IV of his *History of the Pleas of the Crown.* Although his terminology is very different, most of the distinctions which he draws can still be found in our present law. Walker states that it is a myth that the year 1800 marked the birth of the defence of insanity. The trial which led to Hadfield's acquittal in 1800 was a spectacular one.[15] It did lead to the first statute which expressly provided for a special verdict.[16] One must examine the subsequent trials of Arnold and Ferrers however, to ascertain how strictly the criteria of insanity were applied by criminal courts. Success-

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[12] *Supra,* note 1.

[13] Mora, *supra,* note 4 at 20.

[14] Walker, *supra,* note 8 at 35, 52-53, 57, 75, 78, 81.

[15] *R.* v. *Hadfield* (1800), 27 State Trials (New Series) at 1281, in Walker, *supra,* note 8 at 74, 83. Hadfield was a soldier who had served under the Duke of York sustaining head wounds in battle. He attempted to assassinate George III in a box at the Theatre Royal in Drury Lane. He was indicted for high treason. The desire to kill the King arose from delusions that he was the saviour of all mankind, that he had to become a sacrifice to be executed as a martyr.

[16] 40 Geo. III. c. 94.

ful defences of insanity were not completely unheard of even in the 17th century.

Whether the statute of 1800 for the safe custody of insane persons charged with offences would have been drafted in the past with such urgency if Hadfield's target had not been a royal one, or if he had been so obviously insane as to be within the existing definition of insanity, is doubtful, according to Walker.

> From the administrative point of view the incident startled the government into legislation which gave them some control over the subsequent careers of offenders who were found to be insane by the courts. From the judicial point of view, Hadfield — or rather Erskine — established the doctrine that in order to be accused on the grounds of insanity the accused need not be shown to have lacked all understanding, or the ability to distinguish between right and wrong, but could be proved to suffer from a delusion which prompted his act.[17]

The 43 years between Hadfield and McNaghten saw the development of the Napoleonic Code of 1810; the establishment of Fielding's Bow Street Runners and Peel's Metro London Police, 1812-1843; and Haslam's *Medical Jurisprudence As It Relates to Insanity According to the Law of England,* 1817.

Isaac Ray, one of the thirteen founders in 1844 of the American Psychiatric Association, wrote the 1838 classic, *A Treatise on the Medical Jurisprudence of Insanity.*

> Ray was one of those unique personalities who was able to combine a cultivated mind and a high administrative ability, an excellent psychiatric endowment and a profound social consciousness ... [H]e strove to introduce science, particularly medical science, into the courtroom, seeking thus to avoid emotional decisions which so often appear disguised as judicious decisions.[18]

We now reach the key year of 1843. This year witnessed the M'Naghten trial, the debate in the House of Lords, and the subsequent Rules. So much has been written on the M'Naghten Rules that repitition is not required here. The reader may refer to references as listed below.[19] Nonetheless, one must be clear that:

> The Rules are not a definition of insanity as such, but merely point to the degree of insane irresponsibility required by the courts to exculpate the offender ... It cannot be said too often that knowledge must imply a full appreciation of the consequences of an action, the ability to choose between alternative courses of action, and the capacity to feel the appropriate emotion when considering whether or not to commit a criminal offence ... the Rules do not set out to define insanity as such but attempt to set limts to the type of behaviour which can properly be regarded as exonerating the offender on the grounds of his mental state ... the Rules should be abolished, leaving it to the jury to decide whether the accused was insane at the time of the alleged offence and whether his insanity was the whole or partial cause of his act.[20]

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[17] Walker, *supra,* note 8 at 66.

[18] G. Zilboorg, *The Psychology of the Criminal Act and Punishment.* The Isaac Ray Award Book. (New York: Harcourt, Brace & Company, 1954) at 7-8.

[19] Henderson and Gillespie's *Textbook of Psychiatry, supra,* note 5 at 545-48. See also Walker, *supra,* note 8, Chapter 5, at 84-103

[20] F. Whitlock, *Criminal Responsibility and Mental Illness* (London: Butterworths, 1963), Chapters 3-4, at 20-53.

At this point of time it becomes appropriate to review some highlights of the development of psychiatry and law in Ontario.[21] Early assistance for the mentally ill was provided by an Act passed in 1830, authorizing the quarter sessions of the Home District to provide for the relief of the "insane destitute persons" in that district. The clerk of the peace was required to provide an account of money before the grand jury of the sessions for the purpose of maintaining insane persons. This money was presented to the district treasurer for the support of insane persons in gaol or some other place. No institutions were separately provided for the care of the mentally ill; they were usually cared for in the common gaol.

In 1839 an Act was passed to erect an asylum[22] for the reception of insane and lunatic persons within the Province of Upper Canada. In 1846 the jurisdiction of the Court of Chancery was defined in matters pertaining to lunatic, idiots and persons of unsound mind, and their estates. An Act passed in 1851 operated to confine lunatics who constituted a danger to the public when at large. The first part of this statute dealt with insanity as a defence. It also contained a section for the commitment of an insane offender not fit to stand trial. A further Act in 1857 provided for the establishment of an asylum for the criminal convicts, to be located near the penitentiary at Kingston.

In 1885 the trial of Louis Riel for treason highlighted the attitudes towards insanity as a defence. Although there were ample provisions to determine fitness to stand trial,[23] the issue was not raised. Criminal responsibility under the M'Naghten Rules was raised unsuccessfully. The trial was followed by a plea to the Court of Appeal of Manitoba. Although a petition for a Medical Commission was accepted by Sir John A. Macdonald, Riel was executed on November 16th, 1885.[24]

The Revised Statutes of Ontario, 1887, provided for admission of a person to an asylum on the certificates of two medical practitioners. Voluntary admissions were permitted by 1913, and in 1916 alcoholic or drug habituates could be committed.

Canada established its first Criminal Code in 1893. It indicated a modification of the M'Naghten Rules from the "to know the nature and quality of an act" criterion to the more flexible "appreciate". This was later confirmed by the McRuer Royal Commission of 1956.[25]

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[21] See R. Stokes, *History of Forensic Psychiatry in Ontario,* Forensic Clinic Seminar and Personal Communication, 1964.

[22] The asylum was completed in 1846; it is now under total reconstruction as the Queen Street Mental Health Centre in Toronto.

[23] An Act respecting Procedure in Criminal Cases and other matters relating to Criminal Law, S.C. 1869, c. 29.

[24] See E. Markson, C. Greenland and R. E. Turner, *The Life and Death of Louis Riel — A Study in Forensic Psychiatry* (1965), 10 Can. Psychiatr. Assoc. J. 4 at 244.

[25] *Report of the Royal Commission of The Law of Insanity as a Defence in Criminal Cases.* (The Honourable J. C. McRuer, Chairman) (Hull: Queen's Printer, 1956). See also K. Gray, *Meaning of the M'Naghten Rules: The McRuer Report.* Editorial (1958), 3 Can. Psychiatr. Assoc. J. 2.

C. K. Clarke established a psychiatric clinic in 1914 at the Toronto General Hospital.[26] In 1926, *The Psychiatric Hospitals Act*[27] was passed. This led to the establishment of the Toronto Psychiatric Hospital which opened in the following year. Gray considered this period to have been

> ... an early landmark in the development of facilities for the psychiatric examination and treatment of offenders. Due to the foresight of (the late) Dr. C. B. Farrar and (the late) Dr. C. K. Clark, the *Psychiatric Hospitals Act* ... included a provision whereby a judge or magistrate could issue an order for the admission of a person to the Toronto Psychiatric Hospital. Pursuant to this authority many thousands of people have been committed by the courts for a mental examination and report to the court. In the year 1935 the legislation was expanded to provide for similar arrangements throughout Ontario.[28]

The tempo of change and advancement of psychiatry and law was considerably increased with the publication in 1947 of Gray's *Law and the Practice of Medicine,*[29] which contained chapters on mental illness, mental illness in criminal cases, amnesia, and sex offenders. A year later, Gray presented his classic paper "What Is Forensic Psychiatry" to the Ontario Neuropsychiatric Association. In it, he classified psychiatry and law into two main divisions, one of which he designated Psychiatric Jurisprudence and the other Forensic Psychiatry Proper. He considered Psychiatric Jurisprudence as encompassing primarily legal issues. These included the custody of the mentally ill, custody of the estate of the mentally incompetent person, mental illness and testamentary and contractual capacity, mental illness and liability for torts, mental illness in relation to marriage and divorce, abortion or sterilization, and mental illness and crime. In Forensic Psychiatry Proper, the accent was on psychiatry rather than law. It is the application of psychiatry to legal problems. In the ensuing years, Dr. Gray wrote extensively on matters pertaining to psychiatry and law. These publications[30] referred to amnesia, legislation in mental illness, hospital examination of adult offenders, psychiatric evidence in criminal cases and for the courts, psychiatric examinations of sex offenders, psychiatric treatment as an alternative to imprisonment, psychiatry and the criminal code, and amnesia as a defence.

The McGill Forensic Clinic began in 1955 under Dr. B. Cormier, who subsequently studied such diverse subjects as incest, dangerous sexual offenders, and the behaviour of disturbed inmates of the St. Vincent de Paul Penitentiary.

The Forensic Clinic in Toronto was established as an outpatient clinic of the Toronto Psychiatric Hospital in 1956, first under Dr. P. G. Thomson, and then the author until its incorporation into the Clarke Institute of Psy-

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[26] Dr. C. K. Clarke (1857-1924) after whom the Clarke Institute of Psychiatry was named, was a leading pioneer of Canadian psychiatry.

[27] An Act respecting Psychiatric Hospitals, S.O. 1926, c. 71.

[28] K. G. Gray, *Whither Forensic Psychiatry, Editorial* (1962), 7 Can. Psychiatr. Assoc. J. 5 at 201.

[29] K. G. Gray, *Law and the Practice of Medicine* (Toronto: Ryerson Press, 1947). Revised 1955.

[30] The complete set of publications are available from the Clarke Institute of Psychiatry, 250 College Street, Toronto.

chiatry in 1966.[31] This clinic was supported by the Ontario Department of Health and was a teaching unit of the department of psychiatry of the University of Toronto. Also provided were a clinical service to the judiciary and consultations for Crown and defence counsel. By affording treatment services, the clinic staff had a substantial involvement with the provincial probation service. From the outset the clinic developed research programmes, particularly into sexual deviations and sexual offenders.[32]

The progress which the Forensic Clinic in Toronto achieved in the interrelationship of psychiatry and law is illustrated in the following excerpt from its annual report.

> Psychiatry is a body of knowledge with various applications in the fields of human and social disabilities: none is more significant than that concerned with the offender, and with the ways in which offences against the law emerge as behavioural problems. The significance of the forensic psychiatric studies undertaken in the clinic lies in the objectivity of approach and the development of knowledge on the firm basis of valid data. Criminal acts call forth value judgements from the public which is angered, distraught, and otherwise upset by the deviant, the malicious, and the destructive actions of offenders. Such value judgements assert the wrongness of the acts in its enormity, and the culpability of the criminal is pressed to its punitive conclusion. But in terms of human conservation punishment alone is not the simple answer to the violation of society's, law and order. The possibilities of restorative measures, of returning the erring member to a rightful place in the social matrix, are worthy of rational, cool headed, explorations: as with all explorations, detailed direct observations of the presenting phenomena are essential for successful progress. The Forensic Clinic provides this rational approach to the criminal, his offence and the circumstances in which the violation of the law occurred; already the opportunities of treatment, as contrasted with punishment, are dimly seen for careful testing by social psychiatric techniques. The Forensic Clinic has indeed been fortunate in the establishment of a strong collaborative relationship with the courts: the medico-legal confluence has not yet become a flood of mutual endeavour but has attained a stream of common understanding. On the one side, the probing research activities of the clinic have been recognized by the courts as providing helpful firm material for judicial appraisal: on the other side, the openmindedness of the courts has been an encouragement to clinical activity of disciplined kind and to pointed effort in field enquiries.[33]

The *Report of the Royal Commission on the Law of Insanity* was also published in 1956.[34] This Report clearly enunciated the principles to be applied to s. 16 of the Criminal Code and has been of great assistance to psychiatrists in capital and non-capital cases.

Mr. Justice McRuer was chairman of the 1958 Royal Commission on the Criminal Law relating to Criminal Sexual Psychopaths. The *Report*[35]

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[31] R. E. Turner, *The Forensic Clinic, Toronto* (1960) 4 Criminal Law Quarterly 4 at 437.

[32] The list of available reprints can be obtained from the Public Relations Office of the Clarke Institute of Psychiatry.

[33] A. Stokes, Foreword in *Seventh Annual Report,* Forensic Clinic of Toronto Psychiatric Hospital, 1964.

[34] Canada. *Royal Commission on the Law of Insanity as a Defence in Criminal Cases,* (Hull: Queen's Printer, 1956).

[35] Canada. Royal Commission on the Criminal Law Relating to Criminal Sexual Psychopaths, (Hull: Queen's Printer, 1956).

emphasised the need for diagnostic centres for psychiatric examination before sentence, and it underlined the importance of research into all aspects of sexual deviation in order to develop means of correction and prevention.

The dialogue between the legal and psychiatric professions was considerably enhanced by a postgraduate course in Forensic Psychiatry held at the former Toronto Psychiatric Hospital in 1964. The course was sponsored jointly by the Hospital and the Division of Postgraduate Medical Education of the Faculty of Medicine of the University of Toronto.[36] The course was of sufficient popularity and interest that another was held in 1969 at the Clarke Institute of Psychiatry.[37]

These were followed by the publication by the Canadian Mental Health Association (now Mental Health Canada), during the period from 1964 to 1969, of a series of outstanding studies on legislation and psychiatric disorder.[38]

Many readers of this paper will also be familiar with the important *Report of the Canadian Committee on Corrections* under the chairmanship of Mr. Justice R. Ouimet.[39] Of particular interest to those concerned with law and psychiatry are Chapters 12 and 13, which pertain to mentally disordered persons and the dangerous offender. The activities of the Law Reform Commission of Canada are taking into account such recommendations in an active and progressive manner.

II *Psychiatry and the Law To-Day*

This part contains a survey of the activities currently pursued in the Province of Ontario. These activities demonstrate in some measure the extent to which the inter-relationship of psychiatry and law is an operational fact.

One should look initially at the psychiatry and law activities in the provincial court (family division). The clinic operated by the Clarke Institute of Psychiatry is funded jointly by the provincial Ministries of Health and Justice.[40] It accepts referrals for assessment from Judges of the Family Court in the judicial district of York. Almost 80% of the referrals are youngsters who have been found delinquent and for whom a pre-disposition report is

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[36] Psychiatrists received counsel and expert opinion on drunkenness as a defence, privileged communications to psychiatrists, reporting to the police, the adversary system of justice, automatism and social defence, insanity as a defence, fitness to stand trial, and testamentary capacity.

[37] In that course papers were presented on the psychopathic personality, the psychiatrist in court, hearsay as the basis of opinion evidence, family relationships, the *Mental Health Act 1967*, abortion and sterilization, and defences to criminal charges involving psychiatric evidence.

[38] F. C. R. Chalke et al. *The Law and Mental Disorder.* A Report on legislation and psychiatric disorders in Canada. (Published by the Canadian Mental Health Association in Toronto.) One: Hospitals & Patient Care, 1964; Two: Civil Rights & Privileges, 1967; Three: Criminal Process, 1969.

[39] Canada. Committee on Corrections; Report. (Ottawa, Queen's Printer, 1969).

[40] See *supra*, note 31.

requested. 10% are requests for assistance in deciding custody of children in child-welfare court and 10% involve couples in marital disputes. Questions such as fitness for trial and insanity pleas are rarely encountered, and the programme is more a broadly based family mental health service than a forensic service.

The facilities are divided into three clinical teams, each serving a geographic division of Metro Toronto. Each team is composed of psychiatrists, psychologists and social workers, and will soon include teachers and child care workers. They work closely with community agencies and much of the activity is directed to assisting families in utilizing community resources. Some 150 families are currently being seen at the service or given some form of direct care or treatment, and a much larger number are referred to appropriate resources.

Since 70% of all the youngsters sent to Training Schools in Metro Toronto have been assessed by the service, a close liaison with such schools has developed. One form this takes is the provision of psychiatric consultant services to the schools, and particularly to the Reception Assessment Centre at Oakville. Other extensions of the service include the provision of emergency and consultant service to the Observation-Detention Home at 311 Jarvis Street, and the provision of accessibility to its resources to collaborating agencies such as the Children's Aid Society, group homes, and legal clinics.

The service sees approximately 80 youngsters and their families per month for assessment. This number represents approximately 1/6 of the youngsters appearing before Judges in the Family Court. Many of the families seen in this service differ from those who appear in other mental health services. Hopelessness and defeat are commonly encountered attitudes. Many of the families are disintegrated or disintegrating. This group tends to be poorly served by conventional mental health services and so presents a challenge of enormous proportions to the staff. Because of this, thoughtful innovations and commitment form the major philosophical thrust of the programme.

The Lakehead Psychiatric Hospital in Thunder Bay received 32 referrals from court during 1971. Of these, 16 were of Indian or Metis origin. The average length of stay was 40 days, and the average age of the persons referred was 29 years. 20 were returned to court with no evidence of mental disorder and 12 were retained in hospital because of mental illness. In the majority of these cases the charges were eventually dropped. Of the 16 Indian and Metis persons charged, 15 of the incidents involved alcohol. Most referrals were initially for 30 days, but in a few instances where the diagnosis was unclear, a request by the hospital for an extension of the period of observation was favourably entertained by the court.

The following routine investigations are carried out for such court referrals: physical examination, psychological testing, electro-encephalography, brain scan (when indicated), mental status examination, and psychiatric observation.

Forensic services are limited at the North Bay Psychiatric Hospital due to a shortage of psychiatric staff. Nonetheless, the hospital provides in-patient

psychiatric examinations of persons admitted on Judicial Order from the courts in the area which it serves. Prisoners requiring maximum security cannot be accepted. Out-patient forensic examinations are not done but on rare occasions a psychiatric examination is carried out in the local jail.

The Royal Ottawa Hospital directs the following forensic activities: (1) Services provided for the Courts on a pre-trial basis at the police station. These services deal mostly with the issue of fitness, usually before the accused is moved from the police station to court on the first appearance. (2) Services provided for the court for Warrant of Remand, 30 or 60 days. Usually the information sought by the court on these warrants is in relation to treatability, dangerousness and possible criminal responsibility. (3) Order for examination on an out-patient basis by the court. (4) Consultation services provided for the Provincial Probation Service, and after-care services which might include hospitalization in some cases. (5) Assessment services provided for the lawyers who want such service for their clients. These services include possible appearance in court to give expert testimony. (6) Consultation services provided for the jails on the request of the jail physician. Treatment programs are sometimes carried out at the jail setting. They are now preparing to provide some training in psychological awareness and group techniques for the guards. (7) Co-ordination with the School of Criminology, University of Ottawa, to provide supervision for some of their students and lectures in their courses. (8) Experience in Forensic Psychiatry, with field trips to the jail and court for the residents involved in psychiatric training at the University. (9) Other community activities such as involvement with Halfway Houses for prisoners, and workshops and seminars with different associations concerned with the offender.

The Forensic Service at the Hamilton Psychiatric Hospital is an outgrowth of experience from court cases referred to the hospital over many years. As the hospital is divided into regional units, and a more liberal open-area policy was adopted for this, it was felt that it was not fair to non-warrant cases to be behind locked doors for the sake of a few patients who might require security. It was also felt that a specialized unit with highly-trained staff would offer a diagnostic (assessment) function with greater uniformity of operation and reporting. Accordingly, a unit of nine beds was set up to handle male referrals. It was opened on May 15, 1972. In the first six months of operation 50 patients have been assessed at the unit, and consultative help has also been given to the other units in the hospital. Admission has been largely restricted to male patients 18 years of age or over who are charged with an offence and sent on the required documentation for up to either 30 to 60 days. Cases of murder, rape, and arson, requiring maximum security, are still referred to the Penetang Mental Health Centre. Female referrals are sent to the regional unit serving a specific catchment (geographical) area. Provision for these referrals will be made by adding two beds to the Forensic Service early in 1973.

Patients who are considered to be mentally ill and in need of specific treatment are placed on involuntary admission forms under the *Mental Health*

Act[41] and transferred to the appropriate regional treatment unit with the court's approval. Those not considered mentally ill are returned to the referring court with a comprehensive report and evaluation summary.

In Southwestern Ontario the London Psychiatric Hospital provides the following assistance: (1) Examination of accused persons in custody on the request of Crown or defence counsel. (2) Emergency consultation service to police, usually occuring at an Emergency Department of one of the general hospitals or at London Psychiatric Hospital. The effectiveness of this procedure varies considerably depending upon who happens to be on call at the time. The grey area of responsibility relating to personality disorders seems to present most of the potential for conflict, as does the cultural attitude of some of the members of the police and medical personnel as to "how these things have always been handled", e.g., always admit to psychiatric hospital rather than considering alternative management after examination. (3) Remand procedures for examination, under the *Mental Health Act*[42] and the *Criminal Code*.[43] (4) Admission for treatment — usually a minor offence with some psychiatric disorder. Major offences under Warrants of the Lieutenant Governor usually involve women, e.g., infanticide with unsuccessful suicidal attempt. (5) Consultation for defence counsel. This usually involves a person coming to trial on various charges, and who has not been confined to jail during the pre-trial period.

The Mental Health Centre at Penetanguishene includes the Oak Ridge Division, which is a 300 bed maximum security psychiatric hospital for male patients. It serves the entire Province of Ontario. The Hospital accepts male psychiatric patients who present a danger to others. There is a turnover of over 300 a year. About 140 come on Warrants of Remand from courts, having been charged with murder, rape, and other serious offences. Patients found not fit to stand trial or not guilty on account of insanity come on Warrants of the Lieutenant-Governor. Patients serving sentences are transferred from jails, correctional facilities, and penitentiaries. Finally, unmanageable patients are transferred from other Ontario Psychiatric Hospitals.

150 of the patients are involved in an activity therapy programme with occupational therapy, motivation, behaviour modification, and aversion therapy. 150 are involved in a psycho-social approach with encounter groups, ward councils, milieux therapy, and therapeutic community.

The Queen Street Mental Health Centre in Toronto serves the catchment area of the City of Toronto. Although a programme is provided for 15-25 forensic patients, there is not a specific forensic unit in existence at this Centre. In the new complex of buildings currently under construction, a closed secure unit of about 25 to 30 beds is planned. It will hopefully be available in late 1974. At this time, patients are referred for in-patient care from a variety of sources and at different levels of the legal process. They come directly from the courts, the Toronto Jail, provincial and federal correctional institutions, the National Parole system, the Provincial Probation

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41 The Mental Health Act, R.S.O. 1970, c. 269.

42 The Mental Health Act, R.S.O. 1970, c. 269.

43 The Criminal Code, R.S.C. 1970, c. C-34.

Service and from the maximum security hospital at Penetanguishene. In addition, there are a limited number of referrals from the legal profession and the community police. They come at the pre-trial, pre-sentence, and post-sentence levels. In addition, an out-patient service is available for psychiatric assessment purposes. This may include interviewing, psychological testing, electroencephalographic studies, and specialized consultations such as neurological (or x-ray) examinations. Because there is not a specific forensic unit, patients are located in every active treatment unit in the Centre, most of which are "open ward" type.

There is a screening process for each individual through the forensic co-ordinator, for the purpose of gathering all possible information. At the time of admission, the interview is conducted with an admitting team from the designated treatment service. The plan of assessment and treatment (if required) is then formulated. At the appropriate time a comprehensive report is prepared for the referring source, addressing itself to a variety of issues such as suitability for continuing commitment as an involuntary patient because of present mental state or ongoing supervision at an informal status, danger to the person, danger to others, fitness to stand trial, the person's suitability for non-psychiatric counselling (e.g. — probation or other community agency), suitability for bail, prognosis, and any other problems prompting original referral.

In the past two years, involvement with the community and the educational system has greatly increased. Seminars are now conducted with students from Osgoode Hall, the University of Toronto Law School, the senior members of the Provincial Probation Service, nursing students of general hospitals and the Ryerson Institute. Participation in the teaching programme of the University of Toronto, Department of Psychiatry, acquaints residents with the forensic services available at this Centre.

The Muskoka-Parry Sound Health Unit covers an area of 4400 square miles and serves approximately 48,000 people in the districts of Muskoka and Parry Sound. The mental health services which have been created by an Order in Council of the Ontario government are organizations to function within the Health Unit.

There have been a small number of direct referrals by practising barristers representing both defence and the Crown, but by far the majority of its relationships with the court center on the Provincial Courts (Family Division) and bear a close relationship to the Children's and Family Services agencies in each district. Because of a substantial demand for clinical services, however, the forensic assessments that lead to appearances in court have been somewhat curtailed.

The Ontario Ministry of Correctional Services operates the Neuropsychiatric Clinic within the Guelph Correctional Centre, as an assessment unit for adult male offenders. The Clinic handles a wide variety of cases from many referral sources. It is a maximum security setting, and as such is equipped to work with very disturbed inmates. These include arsonists, suicide attemptors, and individuals with an aggressive, assaultive histories. Most of the cases come from the Correctional Centres, primarily the Guelph Correc-

tional Centre, but other cases are referred by medical officers and superintendents of other facilities in the Ministry, either directly or through the Regional Administrators.

The primary function of the Neuropsychiatric Clinic is to assess and make recommendations for the treatment of the individual during his period of incarceration. This involves interviewing, psychological testing, and social observation. Treatment is also a function of the Neuropsychiatric Clinic, although most of this treatment is limited to short-term counselling, medical treatment, or directive therapy. Persons who are more seriously psychiatrically disturbed are sent to psychiatric hospitals. Other individuals are referred to the most appropriate Correctional facility. One of the important roles of the Clinic is to serve as a liaison between Ontario Correctional Services and Ontario psychiatric centres.

Depending on the needs of the individual, the Clinic uses both in-patient and out-patient accommodations. The in-patient accommodation consists of seven single rooms and four dormitories with four beds each. The out-patient accommodation involves using the Guelph Correctional Centre itself. The staff includes a senior psychiatrist, a psychologist, a senior social worker, a psychometrist, a full-time registered nurse and a part-time registered nurse, and a chief clinic officer with two senior clinic officers and eight clinic officers. With this specialized but relatively small staff, the Neuropsychiatric Clinic has found the team approach to be particularly effective. All staff are involved with all patients, and this properly enables the Clinic to obtain a diversity of viewpoints for complete assessment of each referral.

The forensic psychiatry services in Ontario prisons and reformatories (jails, correctional institutions, houses of refuge, and training schools) may be divided into two aspects; that which relates to a mental status assessment conducted prior to sentencing, and that which concerns diagnosis and management of persons with disorders of the mind who are under the care of the Ministry. The latter aspect takes precedence over the former. Persons who require treatment receive the same care and attention as any other resident of Ontario regardless of the concurrent judicial process in which they are involved.

In all counties except York (which includes Metropolitan Toronto), presentence, including pre-trial, assessments are carried out on persons in custody by any qualified medical practitioner through the use of two-party contracts between practitioners and the counsel or Crown attorneys. There is a salaried forensic psychiatrist on the staff of the remand prison for the County of York who not only conducts assessments for the Crown attorneys but also practises as consulting psychiatrist on the jail medical staff.

All psychiatric facilities in the Province, such as the psychiatric wards of public and private general hospitals, out-patient clinics, and provincial mental hospitals, are available to remand and sentenced adults and to juveniles in training schools. Part-time psychiatrists are on the staff of all training schools and all adult institutions which are located in parts of Ontario where psychiatrists are in practice, for the purpose of engaging in the general rehabilitative milieu of the group or team aprpoach as well as for practising medicine. In

addition, the ministry operates a 24 bed psychiatric ward for adult male patients who are referred by medical officers for consultations and management advice.

In recent years the Toronto Jail has given increasing attention to the assessment of inmates' psychological and social problems. A part-time psychiatrist, a full-time social worker, and a psychiatric nurse were first appointed. In the summer of 1971, a full-time psychiatrist and a part-time psychologist were also appointed.

Court assessments are, therefore, based not only on interviews with the psychiatrist and psychiatric nurse, but also, when indicated, upon psychological tests and electroencephalograms performed at the Toronto General Hospital. Twice weekly the head psychiatric nurse arranges a case conference, to discuss a former inmate of the psychiatric block, with the social worker, the classification officer, the psychologist, the psychiatrist, and the correctional officer who have had the most contact with the inmate since the completion of his psychiatric assessment. In addition, twice a week selected inmates join in group therapy with a correctional officer, the full-time chaplain, and the psychiatrist.

Apart from court assessment, inmates are referred by medical officers or the Governor of the Jail for psychological and psychiatric assessments of their behaviour disorders. This reults in a two-way flow of information between the referring person and the psychiatric team. Informal discussion between correctional staff and members of the psychiatric staff results in the former being increasingly alert to the possibility that an inmate's behaviour problems may be the result of a serious mental disorder. Occasionally, the Superintendent or Assistant Superintendent requests that the psychiatric team give an opinion as to whether an inmate is suitable for a Temporary Absence Programme or not. Not infrequently, when an inmate has been transferred to the Toronto Jail from a correctional centre, the psychiatric team is called upon to recommend another correctional centre which has facilities more appropriate to the needs of that particular inmate.

The Forensic Service of the Clarke Institute of Psychiatry is a continuation of the forensic activities of the former Toronto Psychiatric Hospital described in Part I. Since July 1, 1966, it has provided diagnostic and treatment services for the courts and probation services. Although used mainly by the courts of Metropolitan Toronto, it also serves courts elsewhere in the province. It should be noted that forensic clinics of the type maintained within the Clarke Institute of Psychiatry in Toronto are, without doubt, the best media for introducing and educating, both practitioner and student, to the function of forensic psychiatry.

The Institute was established under the *Ontario Mental Health Foundation Act*[44] in 1964. It is a public hospital, similar to general hospitals, under the *Public Hospitals Act*[45] of Ontario. The Institute is a teaching hospital of the University of Toronto, Faculty of Medicine, and under the University-

[44] An Act to establish the Ontario Mental Health Foundation, S.O. 1961, c. 67.

[45] The Public Hospitals Act, R.S.O. 1970, c. 378.

Institute Agreement has many educational programmes for professional workers in the mental health field. The education and research activities of the Institute are firmly rooted in an exemplary comprehensive programme of patient care, including services for children, adolescents, and adults, with out-patient, in-patient, and day care.

The in-patient division has accommodation for 22 patients, both men and women. The service is primarily for assessment, with a report to the court from which the patient was referred. Some in-patients however, undergo treatment following the assessment submited to court, as do a small number of voluntary (informal) non-court cases.

Where a judge has reason to believe that a person in custody who appears before him charged with an offence suffers from mental disorder, he may by order remand that person for admission as a patient to a psychiatric facility for a period of no more than two months. The senior physician is obligated to report in writing to the judge as to the mental condition of the person before the expiration of that time.[46]

The out-patient division undertakes statutory referrals under the Ontario *Mental Health Act*.[47] Where a judge has reason to believe that a person who apears before him charged with or convicted of an offence suffers from mental disorder, the judge may order the person to attend a psychiatric facility for out-patient examination.[48] The senior physician reports in writing to the judge concerning the mental condition of the person. If the report indicates that the person examined needs treatment, the judge may order the patient to attend the psychiatric facility for out-patient treatment.

III *Psychiatry and Law To-morrow*

> If the law is sometimes complex and if psychiatry is sometimes obscure, the area where these disciplines meet and overlap may, understandably, be less than completely clear ... Law is all logic and reason, or at least it sets out to be so. But for a legal system to function, it must be more than merely logical and reasonable. It must be definite. It must be based on precedent. It must rely on rules. And so in the course of time all functioning legal systems become legalistic, and in the process some of the logic and reason gets left behind — Looking at the two, at law and psychiatry, it is not hard to find still other reasons to explain why they do not accommodate more harmoniously. Law tends to be absolutist, psychiatry relativist; law tends to see the world in terms of black and white, psychiatry in gradations.[49]

Nonetheless, although areas of disagreement remain, they are decreasing as each learns from the other. With mutual dialogue, further understanding and agreement will occur in our joint pursuit of resolving many of the ills that beset our society.

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[46] The Mental Health Act, R.S.O. 1970, c. 269, s. 15.

[47] The Mental Health Act, R.S.O. 1970, c. 269.

[48] The Mental Health Act, R.S.O. 1970, s. 269, s. 14(1).

[49] J. R. Robitscher, *Pursuit of Agreement, Psychiatry and the Law* (Philadelphia & Toronto: J. B. Lippincott Company, 1966) at 7.

It has been said in the American literature that:

> To date the interaction between psychiatry and the criminal law system has been frustrating and unproductive. This failure is explained on the basis that psychiatry has always been involved at the request of the legal system and worse, that its tasks and roles have been delineated and defined by the legal system. Psychiatry has accepted this uncritically and unimaginatively. ... Psychiatry has been involved with the criminal law system for quite some time but to date this has not been a happy or, for that matter, a productive relationship.[50]

More appropriate to the Canadian scene are the opinions that forensic psychiatry has "burst its boundaries . . . it has extended out to co-operate with other disciplines. . . . It has become the connection between psychiatry and a host of institutions — the courts, the prisons, the administrative bodies, social agencies and legislatures."[51] Robey quite properly states that

> . . . too often the entire field of forensic psychiatry is thought to consist solely of going into court and testifying on the criminal responsibility of some hapless defendant. However, the knowledge of diagnostic and therapeutic techniques has been gradually extended to include many areas beyond the issue of criminal responsibility. Not only have the criminal sessions made use of this knowledge, but the psychiatrist is now a frequent participant in the juvenile, military and civil courts. Psychiatric evaluation and treatment have become significant aspects of the programmes in correctional and juvenile institutions as well as in special settings for sexual offenders, drug addicts and alcoholics. With the expansion of these horizons, one can readily see that restriction of the role of the forensic psychiatrist to the issue of criminal responsibility would fall far short of meeting the burgeoning needs of the legal system. These have functions pertaining to evaluation, post-trial treatment of the individual, training and research.[52]

Psychiatrists welcome the establishment of the Law Reform Commission of Canada,[53] "to study and keep under review on a continuing and systematic basis the statutes and other laws comprising the laws of Canada with a view to making recommendations for their improvement, modernization and reform." The Commission is to be commended for its policy of maintaining a dialogue with the public to ensure not only that the public is aware of the Commission's activities and reform possibilities, but that the Commission itself has adequate and appropriate response from the public in its very extensive studies.

The Canadian Psychiatric Association, supported by provincial psychiatric associations throughout Canada endorses the principles and aims of the Commission and has organized an extensive network of senior psychiatrists throughout the country as a project leaders on many aspects of law and psychiatry of interest to both professions. The law reform projects to be studied are a clear indication of the extent to which psychiatry and law are involved with each other. Examples are attempted suicide; automatism; capacity to form intent; confidentiality of psychiatric reports; dangerous

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[50] J. Suarez, *Psychiatry and the Criminal Law System,* (1972), 129 Am. J. Psychiatr. 3 at 293.

[51] J. Robitscher, *The New Force of Legal Psychiatry* (1972), 129 Am. J. Psychiat. 3 at 315.

[52] A. Robey and W. Bogard, *The Compleat Forensic Psychiatrist* (1969), 126 Am. J. Psychiat. 4 at 519.

[53] A permanent body established by an act of parliament proclaimed on June 1st, 1971, under the chairmanship of Mr. Justice E. P. Hartt.

offenders and dangerousness; dangerous sexual offenders; diminished responsibility; insanity as a defence; fitness to stand trial; hospital permits or orders; intoxication with alcohol and other drugs; privileged communication; probation/parole and psychiatric services in correctional institutions; psychiatric aspects of sentencing principles; sexual offenders; and finally the broad range of psychiatric aspects of family law.

It is apparent that there is no clearcut distinction between law and psychiatry and forensic psychiatry. All sub-specialties of psychiatry at one point or another involve the law. Much of the focus of forensic psychiatry has been with respect to criminal law, yet it is also involved in less publicized civil law. From our present crossroads, psychiatry and law in Canada can see unlimited horizons. The thrust from genetics, neurochemistry, neurophysiology, neuro-endocrinology, psychophysiology, and various evolving treatment techniques on the one hand, to enlightened law practice, judicial decisions, corrections, and law reform on the other, augur well for psychiatry and law tomorrow.