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BLURRED LINES OF INTOXICATION AND INSANITY

AN EXAMINATION OF THE TREATMENT AT LAW OF ACCUSED PERSONS FOUND TO HAVE COMMITTED CRIMINAL ACTS WHILE IN STATES OF SUBSTANCE-ASSOCIATED PSYCHOSIS, WHERE INTOXICATION WAS VOLUNTARY

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R v Bouchard-Lebrun is a landmark case. In it, the Supreme Court of Canada brings an end to decades-old debate on the question of whether an accused person is exempt from criminal liability for acts committed in a state of substance-induced psychosis. The Court ruled that individuals in these circumstances do not qualify for the defence of not-criminally-responsible-by-reason-of-mental-disorder if the psychosis resulted exclusively from voluntary substance use, but left unanswered the difficult question of whether accused persons with co-occurring and contributing substance use and mental disorder (or some other form of neurobiological vulnerability) are subject to criminal liability to the same extent. Included in this article is an overview of the psychiatric literature on substance-associated psychosis and an examination of the law governing the

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attribution of criminal responsibility in such cases, with particular consideration given to the defences of NCRMD and intoxication. What emerges is the view that, notwithstanding the clarification offered by the Court in R v Bouchard-Lebrun, considerable uncertainty remains in the law itself, and in relation to the quality of the medical evidence on which assessments of criminal liability must now be made. It appears that this is especially so in cases of co-occurring and co-contributing substance use and mental disorder, where the evidentiary lines between intoxication and insanity are blurred and the moral blameworthiness of an accused incapable of clear definition.

La Cour suprême du Canada dans l'affaire R c Bouchard-Lebrun, un arrêt de principe, a mis fin à un débat, remontant à plusieurs décennies, sur la question de savoir si une personne accusée peut être déclarée non criminellement responsable à l'égard d'actes commis alors qu'elle était en état de psychose provoquée par la consommation de substances. La Cour a statué que dans de telles circonstances, ces personnes ne peuvent pas se prévaloir de la défense de non-responsabilité criminelle pour cause de troubles mentaux si la psychose résulte exclusivement de la consommation volontaire de substances. Toutefois, la Cour ne s'est pas prononcée sur la question épineuse de savoir si la responsabilité criminelle de personnes accusées souffrant de troubles mentaux (ou d'un autre type de faiblesse sur le plan neurobiologique) est engagée dans la même mesure lorsque la consommation concomitante de substances est également en cause. Cet article comprend un survol des écrits du domaine de la psychiatrie portant sur les psychoses associées à la consommation de substances et l'examen des principes juridiques régissant la détermination de la responsabilité pénale dans de tels cas, en se penchant tout particulièrement sur les moyens de défense d'intoxication et de non-responsabilité criminelle pour cause de troubles mentaux. De cette analyse ressort l'opinion voulant que nonobstant la clarification offerte par la Cour dans l'arrêt R c Bouchard-Lebrun, une grande incertitude demeure sur le plan juridique en ce qui a trait à la qualité de la preuve médicale sur laquelle doivent désormais reposer les évaluations en vue de déterminer la responsabilité criminelle. Cela est particulièrement vrai, semble-il, dans les cas où les troubles mentaux sont accompagnés de consommation concomitante et concourante de substances. Dans de telles affaires, la ligne de démarcation entre intoxication et troubles mentaux est brouillée sur le plan de la preuve et la culpabilité morale de la personne accusée ne peut être clairement définie.

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1. Introduction

The attribution of criminal responsibility is subject to the fundamental principle that no person shall be held liable for a criminal act without proof of criminal intent.[1] Sir Edmund Coke captured this notion in the oft-quoted phrase, "*actus non facit reum nisi mens sit rea,*" meaning the act is not culpable unless the mind is guilty as well.[2] In Canada, this requirement has been recognized as a principle of fundamental justice guaranteed by section 7 of the *Charter of Rights and Freedoms*.[3] Despite its apparent simplicity, however, the requirement itself is controversial. Stuart observes that "more ink has been spilt over the guilty mind concept than any other criminal law topic … There can be few subjects where the basic principles are the subject of such dispute."[4] Perhaps no more apparent is this dispute than in the treatment of accused persons found to have committed criminal acts while in a state of substance-associated psychosis, where intoxication was voluntary. These cases occupy what preeminent litigation counsel, Robert Mulligan has politely described as "an unsettled area of criminal responsibility."[5]

Indeed, at times, the approach of Canadian courts to allegations of substance-associated psychosis has been wholly contradictory. As set out herein, opposite outcomes have emerged in cases with relatively similar facts. In some of these cases, the courts declared the accused person not-criminally-responsible-by-reason-of-mental-disorder (NCRMD) pursuant to section 16 of the *Criminal Code*.[6] In others, the courts denied this defence, on the view that self-induced mental states are excluded from the reach of section 16. Some courts similarly denied the defence of intoxication, allowing the Crown to rely on the guilt-by-proxy provisions of section 33.1 of the *Criminal Code* to prove *mens rea*.[7] Yet others refused to apply section 33.1, holding instead that the provision is an unwarranted violation of sections 7 and 11(d) of the *Charter* and therefore unconstitutional.

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1 *R v Vaillancourt*, [1987] 2 SCR 636 at 652; *R v City of Sault Ste Marie*, [1978] 2 SCR 1299 at 1309-10.

2 Edmund Coke, *Institutes of the Laws of England* (London: Robert H Small, 1853) as cited in Stephen J Hucker *et al*, eds, *Mental Disorder and Criminal Responsibility* (Toronto: Butterworths, 1985) at 2.

3 *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982 (UK)*, 1982, c 11, ss 1 and 7 [*Charter*]. See, *inter alia*, *Reference re Section 94(2) of the Motor Vehicle Act*, [1985] 2 SCR 486.

4 Donald Stuart, *Canadian Criminal Law: A Treatise*, 6th ed (Toronto: Thomson Carswell, 2011) at 167.

5 *R v Paul*, 2011 BCCA 46 at para. 61, 299 BCAC 85, leave to appeal to SCC refused, [2011] SCCA No 217 [*Paul*].

6 *Criminal Code*, RSC 1985, c C-46, s 16.

7 *Ibid*, s 33.1.

Included in this article is an overview of the psychiatric literature on conditions of substance-associated psychosis, and an examination of the law governing the attribution of criminal liability to accused persons in these circumstances. Particular consideration is given to the law applicable to the defences of NCRMD and intoxication. What emerges is the view that, notwithstanding some clarification offered by the Supreme Court of Canada in the relatively recent case of *R v Bouchard-Lebrun,*[8] considerable uncertainty remains in the law itself, and in relation to the quality of the medical evidence on which assessments of criminal liability must now be made. It appears that this is especially so in cases of co-occurring and co-contributing substance use and mental disorder, where the evidentiary lines between intoxication and insanity are blurred and the moral blameworthiness of an accused incapable of clear definition.

2. Substance-Associated Psychosis

A) Classification of conditions of substance-associated psychosis for diagnostic purposes

Included in the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* (DSM-5) is a condition called *substance/medication-induced psychotic disorder* (substance-induced psychotic disorder).[9] It is defined by the following diagnostic criteria:

A. Presence of one or both of the following symptoms:

   1. Delusions.

   2. Hallucinations.

B. There is evidence from the history, physical examination, or laboratory findings of both (1) or (2):

   1. The symptoms in Criterion A developed during or soon after substance intoxication or withdrawal or after exposure to a medication.

   2. The involved substance/medication is capable of producing the symptoms in Criterion A.

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8 2011 SCC 58, [2011] 3 SCR 575 [*Bouchard-Lebrun*].

9 American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, *5th Edition* (Washington, DC: American Psychiatric Association, 2013).

C. The disturbance is not better explained by a psychotic disorder that is not substance/medication induced. Such evidence of an independent psychotic disorder could include the following:

> The symptoms preceded the onset of the substance/medication use; the symptoms persist for a substantial period of time (e.g., about 1 month) after the cessation of acute withdrawal or severe intoxication; or there is other evidence of an independent non-substance/medication-induced psychotic disorder (e.g., a history of recurrent non-substance/medication-related episodes.)

D. The disturbance does not occur exclusively during the course of a delirium.

E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.[10]

Listed as potential triggers are alcohol, cannabis,[11] hallucinogens (including phencyclidine and related substances), inhalants, and stimulants (including cocaine), as well as sedatives, hypnotics, and anxiolytics.[12]

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10 *Ibid*, "Substance/Medication-Induced Psychotic Disorder."

11 There is controversy in the literature as to the psychoactive effects of cannabis. See, *inter alia*, Laurent Karila *et al*, "Acute and Long-Term Effects of Cannabis Use: A Review" (2014) 20 Current Pharmaceutical Design 4112; Stanley Zammit *et al*, "Effects of Cannabis Use on Outcomes of Psychotic Disorder: Systematic Review" (2008) 18 British J Psychiatry 193. Carroll *et al* argue that the empirical evidence is weak; see Andrew Carroll *et al*, "Drug-Associated Psychoses and Criminal Responsibility" (2008) 26 Behav Sci L 633 at 636-37.

12 DSM-5, *supra* note 9, "Substance/Medication-Induced Psychotic Disorder." In a study of out-of-treatment drug users in St Louis, Thirthalli and Benegal observed prevalence rates as high as 85% for hallucinogens, 82% for phencyclidine, 80% for cocaine, 64% for cannabis, 56% for amphetamine, 54% for opioids, 41% for alcohol and 32% for sedatives. In the case of those severely dependent on cocaine, prevalence rose to 100%; see Jagadisha Thirthalli and Vivek Benegal, "Psychosis Among Substance Users" (2006) 19 Curr Opin Psychiatry 239. *C.f.* Smith *et al*, who report prevalence from users with no diagnosis of dependence to users with severe dependence at rates of 5.2%-100% for amphetamines, 12.4%-80% for cannabis, 6.7%-80.7% for cocaine and 6.7%-58.2% for opiates; see Matthew J Smith *et al*, "Prevalence of Psychotic Symptoms in Substance Users: A Comparison Across Substances" (2009) 50 Comprehensive Psychiatry 245. Variation in prevalence rates may be a function of the duration of prior use as well as the combined use of substances; see Rebecca McKetin *et al*, "Dose-Related Psychotic Symptoms in Chronic Methamphetamine Users: Evidence from a Prospective Longitudinal Study" (2013) JAMA Psychiatry 1; Grant E Sara, *et al*, "Stimulant Use Disorders in People with Psychosis: A Meta-Analysis of Rate and Factors Affecting Variation" (2015) 49 Austl & NZ J Psychiatry 106.

It is noted in the DSM-5 that psychotic symptoms can arise in association with *intoxication* from certain classes of these substances, and *withdrawal* from others.[13] The DSM-5 distinguishes *substance-induced psychotic disorder* from the substance-related disorders of *substance intoxication* and *substance withdrawal* on the basis of insight. It provides that, if the patient understands his or her hallucinations to be the product of substance use, then a diagnosis of substance intoxication or substance withdrawal should be made.[14] Otherwise, clinicians are directed to render a diagnosis of substance-induced psychotic disorder "only when the symptoms of Criterion A predominate in the clinical picture and when they are sufficiently severe to warrant clinical attention."[15]

The DSM-5 differentiates *primary psychotic disorders* from substance-related disorders on the basis of root cause. An individual with substance-induced psychosis may experience hallucinations and delusions in the same way an individual with schizophrenia, for example, might.[16] For a diagnosis of substance-induced psychotic disorder, however, "the substance must be judged to be etiologically related to the symptoms."[17] In making this determination, clinicians are instructed as follows:

> A substance/medication-induced psychotic disorder is distinguished from a primary psychotic disorder by considering the onset, course, and other factors. For drugs of abuse, there must be evidence from the history, physical examination, or laboratory findings of substance use, intoxication, or withdrawal. Substance/medication-induced

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13 DSM-5, *ibid*.

14 *Ibid*.

15 *Ibid*.

16 The nature of the hallucinations may be somewhat different, with individuals in a state of substance/medication-induced psychosis experiencing more visual hallucinations and individuals with other psychotic disorders experiencing more auditory hallucinations. Otherwise, the experience of the individual while in psychosis – whether symptomatic of substance-induced psychotic disorder or a primary psychotic disorder – is comparable. See John Matthew Fabian, "Methamphetamine Motivated Murder: Forensic Psychological/Psychiatric and Legal Applications in Criminal Contexts" (2007) 35 J Psychiatry & L 443 at 449-50; Carol LM Caton *et al*, "Differences Between Early-Phase Primary Psychotic Disorders with Concurrent Substance Use and Substance-Induced Psychoses" (2005) 62 Arch Gen Psychiatry 137 at 141-42 [Caton *et al*, "Differences"]; Andree Dignon *et al*, "Are There Differences Between Primary Psychosis and Substance-Induced Psychosis" (2009) 24 European Psychiatry 441; Alessio Fiorentini *et al*, "Substance-Induced Psychoses A Critical Review of the Literature" (2011) 4 Current Drug Abuse Reviews 228; Sharon Dawe *et al*, "A Comparison of the Symptoms and Short-Term Clinical Course in Inpatients with Substance-Induced Pyschosis and Primary Psychosis" (2011) 40 J Substance Abuse Treatment 95; and Leanne Hides *et al*, "Primary and Substance-Induced Psychotic Disorders in Methamphetamine Users" (2015) 226 Psychiatry Research 91.

17 *DSM-5*, *supra* note 9, "Substance-Induced Psychotic Disorder."

> psychotic disorders arise during or soon after exposure to a medication or after substance intoxication or withdrawal but can persist for weeks, whereas primary psychotic disorders may precede the onset of substance/medication use or may occur during times of sustained abstinence. Once initiated, the psychotic symptoms may continue as long as the substance/medication use continues. Another consideration is the presence of features that are atypical of a primary psychotic disorder (e.g., atypical age at onset or course). For example, the appearance of delusions de novo in a person older than 35 years without a known history of a primary psychotic disorder should suggest the possibility of a substance/medication-induced psychotic disorder. Even a prior history of a primary psychotic disorder does not rule out the possibility of a substance/medication-induced psychotic disorder. In contrast, factors that suggest that the psychotic symptoms are better accounted for by a primary psychotic disorder included persistence of psychotic symptoms for a substantial period of time (i.e., a month or more) after the end of substance intoxication or acute substance withdrawal or after cessation of medication use; or a history of prior recurrent primary psychotic disorders. [18]

Embedded in these instructions is the view that substance-induced psychosis is generally short-lived and resolves with sobriety.[19] In the DSM-IV-TR, clinicians were advised that symptoms persisting beyond four weeks should be considered – “as a rule of thumb” – to result from an independent mental disorder.[20]

B) Criticism that Dichotomous Nature of Diagnostic Criteria does not Reflect Clinical Realities

The DSM-5 adopts the diagnostic criteria of the DSM-IV-TR, albeit with some revision to language and descriptive content, notwithstanding considerable criticism to the effect that the criteria are confusing, and that

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[18] *Ibid*.

[19] See Fiorentini *et al*, *supra* note 16 at 228-29. Clinicians are cautioned elsewhere in the DSM-5 that the psychotic symptoms produced by agents such as amphetamines, phencyclidine, and cocaine can persist for “weeks or longer despite removal of the agent and treatment with neuroleptic medication,” and that it can be difficult to properly distinguish substance-induced psychotic disorder from a primary psychotic disorder as a result. See DSM-5, *supra* note 9, “Substance/Medication-Induced Psychotic Disorder.”

[20] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, *4th Edition*, *Text Revisions* (Washington, DC: American Psychiatric Association, 2000), “Substance-Related Disorders.” This purported rule of thumb overlooks the fact that some psychoactive substances, including cannabis, remain in the user’s system beyond the four-week period; see Steve Mathias *et al*, “Substance-Induced Psychosis: A Diagnostic Conundrum” (2008) 69 J Clin Psychiatry 358 at 363; Marta Di Forti *et al*, “Daily Use, Especially of High-Potency Cannabis, Drives the Earlier Onset of Psychosis in Cannabis Users” (2014) 40 Schizophrenia Bull 1509.

the distinction between substance-related disorders (including substance intoxication, substance withdrawal, and substance induced psychotic disorder) and primary psychotic disorders is incompatible with clinical realities.[21] In this regard, Leong *et al* report as follows:

> For each diagnosis, the diagnostic criteria force a dichotomous choice between assigning causation to either the exogenous substance or a preexisting or independent mental disorder, when in clinical practice the contributions may be derived from a variety of factors, including acute or recent consumption of a substance and the individual's preexisting neurobiological matrix.[22]

In some cases, the onset of psychosis may be attributable to the combination of substance use and underlying neurobiological factors,[23] the relative impact of which may not be obvious or even capable of ascertainment.[24]

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21 Sources cited *ibid*. See also Henrik Anckarsäter, "Beyond Categorical Diagnostics in Psychiatry: Scientific and Medicolegal Implications" (2010) 33 Int'l J L & Psychiatry 59, for a critique of categorical diagnostics generally.

22 Gregory B Leong *et al*, "Commentary: Intoxication and Settled Insanity – Unsettled Matters" (2007) 35 J American Acad of Psychiatry & L 183 at 184. For a useful discussion of the co-occurrence of substance use and psychosis, see Canadian Centre on Substance Abuse, *Concurrent Disorders: Substance Abuse in Canada* (Ottawa: Canadian Centre on Substance Abuse, 2009) at 49-67. Some researchers report that environmental stressors also contribute to onset. See, *inter alia*, Brendan D Kelly, "Structural Violence and Schizophrenia" (2005) 61 Soc Sci & Med 721; Robert F Leeman *et al*, "Behavioral and Neurological Foundations for the Moral and Legal Implications of Intoxication, Addictive Behaviors and Disinhibition" (2009) 27 Behav Sci L 237. For a discussion of amphetamine-induced psychosis in particular, see Jørgen G Bramness *et al*, "Amphetamine-Induced Psychosis – a Separate Diagnostic Entity or Primary Psychosis Triggered in the Vulnerable?" (2012) 12 BMC Psychiatry 221; Jennifer H Hsieh *et al*, "The Neurobiology of Methamphetamine Induced Psychosis" (2014) 8 Frontiers in Human Neuroscience 537.

23 Recent research suggests that there may be a shared genetic risk between substance-induced psychosis and primary psychotic disorders. See Masashi Ikeda *et al*, "Evidence for Shared Genetic Risk Between Methamphetamine-Induced Psychosis and Schizophrenia" (2013) 38 Neuropsychopharmacology 1864; Allan V Kalueff *et al*, "Hidden Heritability and Genetic Parsing of Complex CNS Disorders" (2015) 3 Stress Brain Behav 1.

24 The nature and extent of co-occurrence are well documented, as are the corresponding diagnostic and treatment challenges that assessing psychiatrists face. See, *inter alia*, Darrel A Regier *et al*, "Comorbidity of Mental Disorders with Alcohol and Other Drug Abuse: Results from the Epidemiological Catchment Area (ECA) Study" (1990) 264(19) JAMA Psychiatry 2511; Jonathan Rabinowitz *et al*, "Prevalence and Severity of Substance Use Disorders and Onset of Psychosis in First-Admission Psychotic Patients" (1998) 28 Psychol Med 1411; Valborg Helseth *et al*, " Substance Use Disorders among Psychotic Patients Admitted to Inpatient Psychiatric Care" (2009) 63

For this reason, Mathias *et al* have suggested that the nomenclature of substance-*induced* psychosis be abandoned and replaced with that of substance-*associated* psychosis:

> This reflects the growing literature highlighting an association between substance use (particularly cannabis and stimulant use) and psychosis onset, while acknowledging that the underlying etiology still remains undetermined. In addition, … it is exceedingly difficult to reliably differentiate substance-induced psychoses from schizophrenia-spectrum disorders, and it is clinically challenging, if not impossible, to accurately conclude that the presentation unreservedly reflects a substance-induced state. To this end, a diagnosis of [substance-associated psychotic disorder] implies an association between state and substance, rather than causation, which more accurately reflects our current understanding of the interplay between psychotic symptoms and substance use.[25]

Consistent with this approach, Carroll *et al* have identified at least four means by which psychosis may manifest *in association with* drug use:

> Psychotic symptoms may be part of an intoxication syndrome, and resolve rapidly with the excretion of the psychotogenic (that is, psychosis-causing) substance from the body.
>
> Relatively short-lived psychotic symptomology may be judged to be due to the direct physiological effects of an ingested substance, and the symptoms may persist for a short period (days or weeks) after excretion of the substance...
>
> A person's use of a psychoactive substance, either once or, more commonly, repeatedly, may be associated with the emergence of a psychotic illness, which then continues to have an independent long-term existence even in the absence of ongoing substance use.

Nordic J Psychiatry 72; Martin Lambert *et al*, "The Impact of Substance Use Disorders on Clinical Outcome in 643 Patients with First-Episode Psychosis" (2005) 112(2) Acta Psychiatr Scan 141, as cited in Mathias *et al*, *supra* note 20 at 358; Dominique Morisano *et al*, "Co-occurrence of Substance Use Disorders with other Psychiatric Disorders: Implications for Treatment Services" (2014) 31 Nordic Stud on Alcohol & Drugs 5.

25 *Ibid* at 364-65. Similar concerns are raised in Bruce J Rounsaville, "DSM-5 Research Agenda: Substance Abuse/Psychosis Comorbidity" (2007) 33 Schizophr Bull 947; Jeff Feix and Greg Wolber, "Intoxication and Settled Insanity: A Finding of Not Guilty by Reason of Insanity" (2007) 35 J American Acad Psychiatry & L 172; Joel Watts, "Updating Toxic Psychosis into 21st-century Canadian: *Bouchard-Lebrun v R"* (2013) 41 Amer Acad Psychiatry & Law 374.

> A person with an established psychotic illness may engage in substance abuse, which appears to precipitate psychotic relapses.[26]

However, even if the relationship between substance use and psychosis is recast as one of association and not simple causation, as Mathias *et al* have suggested, it still may not be possible for clinicians to accurately differentiate between these four categories of association.[27] As Feix and Wolber observe, it is "difficult, if not impossible to determine whether the psychosis was induced or released; in other words, did the drug cause the psychosis or did it merely weaken an existing tenuous ego structure, allowing for the breakthrough of a pre-existing, underlying psychosis?"[28]

Fiorentini *et al* attribute some of these complications to the common neurobiological processes at play in cases of substance-associated psychosis, which commonalities can lead to "major problems" of differential diagnosis.[29] They underline this point by reference to an early

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26 Carroll *et al*, *supra* note 11 at 634. Following a similar analysis, Wilkinson *et al* suggest that "exposure to cannabis is associated with a number of distinct syndromes, including (1) acute psychosis associated with cannabis intoxication; (2) acute psychosis that lasts beyond the period of acute intoxication; and (3) persistent psychotic disorders;" see Samuel T Wilkinson *et al*, "Impact of Cannabis Use on the Development of Psychotic Disorders" (2014) 1 Current Addiction Reports 115.

27 Jordaan *et al* tested the hypothesis that alcohol-induced psychotic disorder is a discrete clinical entity that could be differentiated from schizophrenia and alcohol dependence on the basis of standardized clinical assessment, but found only modest support for that proposition; see Gerhard P Jordaan *et al*, "Alcohol-Induced Psychotic Disorder: A Comparative Study on the Clinical Characteristics of Patients with Alcohol Dependence and Schizophrenia" (2009) 70 J Stud on Alcohol & Drugs 870. However, in a subsequent review of the literature, Jordaan and Emsley concluded that alcohol-induced psychotic disorder can be clinically distinguished from schizophrenia but is associated with high co-morbidity with other psychiatric disorders; see Gerhard P Jordaan and Robin Emsley, "Alcohol-Induced Psychotic Disorder: A Review" (2014) 29 Metabolic Brain Disease 231.

28 Feix and Wolber, *supra* note 25 at 179. Similarly, Watts, *supra* note 25 at 8, notes that "[t]he demarcation between substance-induced psychosis and an endogenous psychotic disorder may not be as clear as the legal process would often like, given the current state of our knowledge and science." See also Michael Flaum and Susan K Schultz, "When Does Amphetamine-Induced Psychosis Become Schizophrenia" (2003) 1:2 Focus 205. In a recent study of NCR accused in Canada, Crocker *et al* found that co-occurring diagnoses had been rendered in 49.2% of cases involving "serious violence offences," approximately one third of which involved co-occurring psychotic disorders and substance use; see Anne G Crocker *et al*, *Description and Processing of Individuals Found Not Criminally Responsible on Account of Mental Disorder Accused of "Serious Violent Offences"* (Montreal: Douglas Mental Health University Institute, March 2013), online: Douglas Mental Health University Institute <https://ntp-ptn.org/NCRMD-SVO-NTPteam_March_2013.pdf>.

29 Fiorentini *et al*, *supra* note 16 at 228.

study of Fennig *et al* involving patients with first-episode psychosis. These researchers found that a clear diagnosis could not be made in almost 10% of cases, and that the diagnostic process requires "longitudinal assessment after a period of sustained abstinence that is often impractical because of the relapsing nature of substance abuse and limited access to in-patient care."[30] More alarming, in a subsequent study by Shaner *et al*, it was found that psychiatrists were unable to render a clear diagnosis in 78% of cases due to insufficient periods of abstinence.[31] It is perhaps not surprising then to find as well a considerable degree of diagnostic instability in cases of substance-associated psychosis. In a study of patients admitted to psychiatric emergency departments in New York, Caton *et al* found that 25% of cases changed within a one-year period from an initial diagnosis of substance-induced psychotic disorder to an outcome diagnosis of primary psychotic disorder.[32] Braithwaite *et al* examined the files of the Quebec Review Board for the period of 2000-05, and reported a mere 33% chance that an initial diagnosis of substance-induced psychosis would be supported in subsequent Review Board proceedings.[33] For that population, the likelihood of the diagnosis transitioning to schizo-spectrum disorder, bipolar disorder and/or substance use disorder was, collectively, 34.17%.

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30 Shmuel Fennig *et al*, "Psychotic Patients with Unclear Diagnoses" (1995) 183 J Nerv Ment Dis 207, as cited in Fiorentini, *supra* note 16 at 229.

31 Andrew Shaner *et al*, "Sources of Diagnostic Uncertainty for Chronically Psychotic Cocaine Abusers" (1998) 49 Psychiatry Serv 684.

32 Carol LM Caton *et al*, "Stability of Early-Phase Primary Psychotic Disorders with Concurrent Substance Use and Substance-Induced Psychosis" (2007) 190 British J Psychiatry 105 [Caton *et al*, "Stability"]. See also e.g. *R v Fisher*, 2006 NSSC 206; Aravind Komuravelli *et al*, "Stability of the Diagnosis of First-Episode Drug-Induced Psychosis" (2011) 35 The Psychiatrist 224 (report, in a study wherein psychiatric patients were followed for a minimum of two years or until discharge, that diagnosis changed to schizophrenia, schizoaffective disorder, bipolar affective disorder, psychosis not otherwise specified, acute and transient psychosis or delusional disorder in 78% of cases. It is possible that these cases represent not a misdiagnosis but a conversion of the patient's condition from one of substance-induced psychosis to a primary psychotic disorder). See also Jussi A Niemi-Pynttäri *et al*, "Substance-Induced Psychoses Converting into Schizophrenia: A Register-Based Study of 18,478 Finnish Inpatient Cases" (2013) 74(1) J Clin Psychiatry 94-99, for research on conversion risk. It is noteworthy also that diagnostic instability of this nature is particularly problematic from a treatment perspective as well; see AW Bacon *et al*, "Substance-Induced Psychosis" (1998) Semin Clin Neuropsychiatry 70.

33 Erika Braithwaite *et al*, "Patterns of Diagnostic Stability in Quebec Review Board Files" (Paper delivered at 11th Annual Conference of the International Association of Forensic Mental Health Services, Barcelona, 2011) [unpublished].

3. Treatment at Law

Section 672.14 of the *Criminal Code* limits the duration of psychiatric assessment orders to 30 days.[34] It does so notwithstanding the diagnostic challenges at play in circumstances of substance-associated psychosis, and the apparent need for longitudinal assessment in these cases. In "compelling circumstances," the court may extend the assessment period.[35] Even then, however, it cannot allow the accused to be detained beyond 60 days.[36] It would appear, in light of the literature described above, that there is a real and substantial risk that any diagnosis rendered in this limited period, and without the benefit of subsequent longitudinal assessment, could be inaccurate. In the discussion that follows, specific consideration is given as to the manner in which this risk of diagnostic error – and the corresponding risk of a subsequent miscarriage of justice – in cases of substance-associated psychosis are compounded by the operation of the law itself, particularly in relation to the application of the defences of intoxication and NCRMD.

A) Defence of Intoxication

1) Availability of Defence in Circumstances of "Extreme-intoxication-akin-to-insanity"

The origins of the current intoxication defence can be traced to the 1920 decision of the House of Lords in the case of *DPP v Beard.*[37] In his speech, Lord Birkenhead LC observed as follows:

> Under the law of England as it prevailed until early in the 19th century voluntary drunkenness was never an excuse for criminal misconduct; and indeed the classic authorities broadly assert that voluntary drunkenness must be considered rather an aggravation than a defence. This view was in terms based upon the principle that a man who by his own voluntary act debauches and destroys his will power shall be no better situated in regard to criminal acts than a sober man.[38]

In the result, the House of Lords held that a defence of intoxication should be available to accused persons, but only in limited circumstances. Lord Birkenhead articulated these circumstances, and the rules intended to govern the application of the defence, in his speech:

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34 *Criminal Code*, *supra* note 6, s 672.14.

35 *Ibid*, s 672.14(3).

36 *Ibid*.

37 [1920] AC 479.

38 *Ibid* at 494.

> 1. That insanity, whether produced by drunkenness or otherwise, is a defence to the crime charged. ....
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> 2. That evidence of drunkenness which renders the accused incapable of forming the specific intent essential to constitute the crime should be taken into consideration with the other facts proved in order to determine whether or not he had this intent.
>
> 3. That evidence of drunkenness falling short of a proved incapacity in the accused to form the intent necessary to constitute the crime, and merely establishing that his mind was affected by drink so that he more readily gave way to some violent passion, does not rebut the presumption that a man intends the natural consequences of his acts.[39]

These rules subsequently became known as the *Beard Rules*. The Supreme Court of Canada endorsed the latter two *Beard Rules* in the 1931 case of *MacAskill v The King*.[40] Taken together, the *Beard Rules* operate so as to allow an accused person to plead intoxication by way of defence to a specific intent offence, if the effects of intoxication rendered the accused incapable of forming the specific intent required for conviction. For accused persons in these circumstances, however, intoxication offers only a *partial defence*. In reliance on the *Beard Rules*, an accused might be acquitted of a specific intent offence, but he or she could still be convicted of any lesser included general intent offence.[41]

The *Beard Rules* are subject to an important qualification subsequently recognized by the Supreme Court of Canada in *R v Robinson*.[42] In that case, the Court concluded that the *Beard Rules* violated sections 7 and 11(d) of the *Charter*, and could not be saved under section 1, to the extent that they required *proof of incapacity* on the part of the accused. Thus, the *Beard Rules* must be modified to allow the defence of intoxication to proceed as a complete defence to a specific intent offence, if there is reasonable doubt as to whether the defendant formed *actual* specific intent by reason of intoxication. In other words, it is sufficient for the accused to show a lack of intent. It is not necessary for the accused to go further to show *incapacity to form that intent*.

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39 *Ibid* at 500-02.

40 [1931] SCR 330.

41 Naturally, this defence is not available in circumstances where the accused person deliberately consumes drugs or alcohol for the purpose of committing the offence (so-called “liquid courage”); see *A-G for N Ireland v Gallagher*, [1963] AC 349.

42 [1996] 1 SCR 683. See also *R v Seymour*, [1996] 2 SCR 252; *R v Lemky*, [1996] 1 SCR 757.

Naturally, the question later arose as to whether a complete defence should be similarly available to accused persons charged with general intent offences. The Supreme Court of Canada considered this issue in *Leary v The Queen.*[43] The complainant testified that the accused was intoxicated when he forced her at knifepoint to submit to various sexual acts. In his instructions to the jury, the trial judge stated that "drunkenness is not a defence to a charge of this sort."[44] Several issues were identified on appeal, including the viability of the distinction at law between specific intent offences and general intent offences. Of significance for the purposes of this analysis, however, is the ruling of the Court with respect to the availability of the defence of intoxication in circumstances where there is reasonable doubt as to whether the defendant formed even the minimal *mens rea* required for conviction of a general intent offence. The Supreme Court of Canada held that, in such circumstances, the *mens rea* of the general intent offence is satisfied by proof of voluntary intoxication. In other words, the Crown can rely on the recklessness associated with voluntary intoxication to establish fault on the part of the accused.[45] In this way, the so-called *Leary Rule* allows for *substituted mens rea* or *guilt-by-proxy.* The effect of the *Leary Rule* is to facilitate the conviction of an accused person for a general intent offence even in the absence of proof beyond of reasonable doubt of the *mens rea* elements of the offence.

Guilt-by-proxy is a concept not entirely foreign to Canadian law.[46] The doctrine of transferred intent permits the transfer of *mens rea* from one offence to another, but only so long as the *actus reus* of each offence is the same. This is not the case with the *Leary Rule*. The transfer of the *mens rea* of voluntary intoxication to the *actus reus* of a criminal offence, such as assault or murder, is exceedingly more controversial. In the subsequent case of *R v Daviault,* Cory J described the competing perspectives that arose in response to the *Leary Rule*:

> The supporters of the *Leary* decision are of the view that self-induced intoxication should not be used as a means of avoiding criminal liability for offences requiring only a general intent. They contend that society simply cannot afford to take a different position since intoxication would always be the basis for a defence despite

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43 [1978] 1 SCR 29 [*Leary*].

44 *Ibid* at para 1.

45 *Ibid*; see also *R v Daley*, 2007 SCC 53 at para 36, [2007] 3 SCR 523.

46 See Paul H Robinson, "Four Distinctions That Glanville Williams Did Not Make: The Practical Benefits of Examining the Interrelation Among Criminal Law Doctrines" in Dennis Baker, ed, *The Sanctity of Life and the Criminal Law: Essays in Honor of Glanville Williams* (Cambridge, UK: Cambridge University Press, 2013), for a discussion of equivalent doctrines of imputation in American law, including the doctrines of voluntary intoxication, complicity, causing a crime by an innocent, and transferred intent, as well as the Pinkerton Doctrine (conspiracy).

> the fact that the accused had consumed alcohol with the knowledge of its possible aggravating effects. Supporters of the *Leary* decision argue that to permit such a defence would "open the floodgates" for the presentation of frivolous and unmeritorious defences.
>
> Those who oppose the decision contend that it punishes an accused for being drunk by illogically imputing to him liability for a crime committed when he was drunk. Further, it is said that the effect of that decision is to deny an accused person the ability to negate his very awareness of committing the prohibited physical acts. That is to say the accused might, as a result of his drinking, be in a state similar to automatism and thus completely unaware of his actions, yet he would be unable to put this forward as a factor for the jury to consider because his condition arose from his drinking. In such cases, the accused's intention to drink is substituted for the intention to commit the prohibited act. This result is said to be fundamentally unfair. Further, it is argued that the floodgates argument should not have been accepted because juries would not acquit unless there was clear evidence that the drunkenness was of such a severity that they had a reasonable doubt as to whether the accused was even aware that he had committed the prohibited act...[47]

In the *Daviault* case, the Supreme Court of Canada was called on to consider these arguments anew, and respond to the particular question of whether substituted *mens rea* was permissible under sections 7 and 11(d) of the *Charter*.[48] These issues were not taken up in *Leary*, as that case predated the enactment of the *Charter*.

The complainant in *Daviault* was a 65-year-old woman. She was partially paralysed and confined to a wheelchair. The accused was a friend whom the complainant had invited to her home. It was the evidence of the complainant that the accused arrived at approximately 6:00 pm with a 40-ounce bottle of brandy. She drank a small amount of that brandy before falling asleep. The complainant testified to the effect that, later in the night, the accused intercepted her en route to the bathroom, wheeled her to the bedroom, and sexually assaulted her. The accused was a chronic alcoholic. There was evidence at trial which suggested that the accused drank the entirety of the 40-ounce bottle of brandy (apart from the small amount he shared with the complainant) between the hours of 6:00 pm and 3:00 am. He allegedly consumed seven or eight bottles of beer earlier in the day. A pharmacologist testified that, if the accused had indeed consumed this quantity of beer followed by 35 ounces of brandy, his blood-alcohol ratio would have been between 400 and 600 milligrams per 100 millilitres of blood. It was the view of this expert that such extreme intoxication could

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47 *R v Daviault*, [1994] 3 SCR 63 at paras18-19 [*Daviault*].

48 *Ibid*.

trigger an episode of "l'amnésie-automatisme" wherein the individual experiences a break with reality and loses control over their actions.[49]

Cory J, writing for the majority of the Court, affirmed the principle that criminal responsibility can be imposed only if the conduct of the accused was voluntary and intentional. He recognized this as a principle of fundamental justice, and held that it applies equally to general intent offences as it does to specific intent offences, even in cases involving voluntary intoxication. Cory J reasoned as follows:

> The mental aspect of an offence, or *mens rea,* has long been recognized as an integral part of crime. The concept is fundamental to our criminal law. That element may be minimal in general intent offences; nonetheless, it exists…The necessary mental element can ordinarily be inferred from the proof that the assault was committed by the accused. *However, the substituted mens rea of an intention to become drunk cannot establish the mens rea to commit the assault.*
>
> …
>
> The consumption of alcohol simply cannot lead inexorably to the conclusion that the accused possessed the requisite mental element to commit a sexual assault, or any other crime. Rather, the substituted *mens rea* rule has the effect of eliminating the minimal mental element required for sexual assault. *Furthermore, mens rea for a crime is so well-recognized that to eliminate that mental element, an integral part of the crime, would be to deprive an accused of fundamental justice*.[50]

Consequently, the *Leary Rule* was found to offend both section 7 and 11(d) of the *Charter*. Further, in the words of Cory J, "[T]o deny that even a very minimal mental element is required for sexual assault offends the *Charter* in a manner that is so drastic and so contrary to the principles of

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49 *Ibid* at para. 73. The factual matrix underlying this decision has since been called into question. In *R v Dow*, 2010 QCCS 4276, (2010), 261 CCC (3d) 399, appeal allowed on other grounds (2014) QCCA 1416, (2014), 115 WCB (2d) 457 [*Dow*], the Quebec Superior Court rejected the accused's claim of alcohol-induced automatism, holding at 101-102 that "the judicial definition of extreme intoxication akin to automatism given by the Supreme Court in *Daviault* is inconsistent with the scientific evidence tendered in the case at bar, for situations involving over-consumption of alcohol alone. The scientific basis in *Daviault*, which was taken for granted then and after, led to a wrong conclusion. The latter must be set aside."

50 *Daviault*, *ibid* at paras 40 and 42 [emphasis added]. Some jurists characterize voluntariness as an aspect of the *actus reus* of the offence. See, *inter alia*, *R v Parks*, [1992] 2 SCR 871 at para 42; *R v Théroux*, [1993] 2 SCR 5 at para 20. In *Daviault*, Cory J explained at para 66 that his reasoning applies with equal force whether voluntariness is part of the *mens rea* or *actus reus*.

fundamental justice that it cannot be justified under s. 1 of the *Charter.*"[51] In the result, the majority allowed the accused's appeal from conviction and remitted the matter for a new trial.

In his judgment, Cory J rejected the argument that voluntary intoxication could be substituted for the *mens rea* requirements of general intent offences without violating *Charter* rights:

> I cannot accept that contention. *Voluntary intoxication is not yet a crime*. Further, it is difficult to conclude that such behaviour should always constitute a fault to which criminal sanctions should apply. However, assuming that voluntary intoxication is reprehensible, it does not follow that its consequences in any given situation are either voluntary or predictable. Studies demonstrate that the consumption of alcohol is not the cause of the crime. A person intending to drink cannot be said to be intending to commit a sexual assault.[52]

Instead, Cory J held, the *Charter* requires that a complete defence be available to accused persons, even in response to general intent offences. He described the parameters of the defence as follows:

> In my view, the *Charter* could be complied with, in crimes requiring only a general intent, if the accused were permitted to establish that, at the time of the offence, he was in a state of extreme intoxication akin to automatism or insanity. Just as in a situation where it is sought to establish a state of insanity, the accused must bear the burden of establishing, on the balance of probabilities, that he was in that extreme state of intoxication. This will undoubtedly require the testimony of an expert. Obviously, it will be a rare situation where an accused is able to establish such an extreme degree of intoxication. Yet, permitting such a procedure would mean that a defence would remain open that, due to the extreme degree of intoxication, the minimal mental element required by a general intent offence had not been established. To permit this rare and limited defence in general intent offences is required so that the common law principles of intoxication can comply with the *Charter*.[53]

Hence, in reliance on the judgment of the majority in this case, an accused person could obtain a full acquittal to a general intent offence if the accused proved, on a balance of probabilities, that he or she was in a state of extreme intoxication akin to automatism *or insanity*, and lacked the requisite *mens rea* as a result.[54]

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51 *Daviault*, *ibid* at para 47.

52 *Ibid* at para 45 [emphasis added].

53 *Ibid* at para 67.

54 Cory J acknowledged that the reverse onus violated section 11(d) of the *Charter*, but took the view that the violation was justified under section 1. *C.f.* Gerry Ferguson, "The Intoxication Defence: Constitutionally Impaired and in Need of Rehabilitation"

A compelling argument can be made that psychosis is a mental state akin to insanity, and ought to be captured by the *Daviault* defence regardless of whether the psychotic episode arose as a result of intoxication alone or a combination of substance use and underlying neurobiological factors.[55] Indeed, in the recent case of *Bouchard-Lebrun*, the Supreme Court of Canada considered the application of section 33.1 of the *Criminal Code* to an individual in circumstances of ecstasy-induced psychosis, which provision is only applicable if the *Daviault* defence is otherwise available to the accused. By implication, it would appear that the Court is prepared to treat substance-induced psychosis as a form of extreme intoxication akin to insanity.[56] Coughlan *et al* agree that a defence should be available in these cases, saying that there can be no moral basis on which to convict accused persons who commit criminal acts while in the throes of a psychotic episode.[57]

2) Daviault Defence Subject to Section 33.1 of the Criminal Code, the Constitutionality of which Remains in Doubt

As noted above, the question of whether an accused might be convicted of a lesser included offence, in circumstances where the *Daviault* defence is otherwise available, is subject to the application of section 33.1 of the *Criminal Code*. It provides as follows:

> 33.1(1) It is not a defence to an offence referred to in subsection (3) that the accused, by reason of self-induced intoxication, lacked the general intent or the voluntariness required to commit the offence, where the accused departed markedly from the standard of care as described in subsection (2).
>
> (2) For the purposes of this section, a person departs markedly from the standard of reasonable care generally recognized in Canadian society and is thereby criminally at fault where the person, while in a state of self-induced intoxication that renders the person unaware of, or incapable of consciously controlling, their behaviour, voluntarily or involuntarily interferes or threatens to interfere with the bodily integrity of another person.
>
> (3) This section applies in respect of an offence under this Act or any other Act of Parliament that includes as an element an assault or any other interference or threat of interference by a person with the bodily integrity of another person.

(2012) 57 SCLR (2d) 111 at 137-40, in which Ferguson argues that the reverse onus aspect of the *Daviault* defence is constitutionally infirm.

55 *Bouchard-Lebrun*, *supra* note 8.

56 See also *R v Wells* (2013), 334 Nfld & PEIR 263 (NL Prov Ct) [*Wells*].

57 Steve Coughlan *et al*, *Annual Review of Criminal Law 2011* (Toronto: Carswell, 2012) at 205-11.

Collectively, these provisions operate so as to remove the *Daviault* defence from the reach of accused persons if they are charged with crimes involving personal violence and their intoxication is found to have been "self-induced." That term has been interpreted to mean ingestion was voluntary, the accused knew or ought to have known the substance was an intoxicant, and the risk of intoxication was or should have been within the contemplation of the accused.[58] The *Daviault* defence continues to be available to accused persons in all other circumstances.

Section 33.1 was introduced by way of Bill C-72, entitled *An Act to amend the Criminal Code (self-induced intoxication)*.[59] The governing Liberal Party tabled Bill C-72 on February 24, 1995, less than five months after the Supreme Court of Canada rendered its judgment in *Daviault* and following vocal criticism of the *Daviault* decision, particularly from those concerned about the reported correlation between alcohol use and violence against women.[60] These views are reflected in the unusually long preamble included Bill C-72. Of note are the following clauses:

> WHEREAS the Parliament of Canada recognizes that violence has a particularly disadvantaging impact on the equal participation of women and children in society and on the rights of women and children to security of the person and to the equal protection and benefit of the law as guaranteed by sections 7, 15 and 28 of the Canadian Charter of Rights and Freedoms;
>
> WHEREAS the Parliament of Canada recognizes that there is a close association between violence and intoxication and is concerned that self-induced intoxication

[58] *R v Chaulk*, 2007 NSCA 84, (2007), 223 CCC (3d) 174 at para 47 [*Chaulk*]. Ignorance of the strength of the substance, or the intoxicating effects of the combination of substances, is no excuse; see *R v Allen*, [1988] Crim. LR 698 (CA); *R v Abel* (1999), 134 CCC (3d) 155 (Alta CA). See also *R v Brenton* (1999), 28 CR (5th) 308 (NWTSC), rev'd on other grounds, 2001 NWTCA 1, (2001) 199 DLR (4th) 119 [*Brenton*]; *R v Honish* (1991), 68 CCC (3d) 329 (Alta CA), aff'd [1993] 1 SCR 458; *R v Vickberg* (1998), 16 CR (5th) 164 (BCSC) [*Vickberg*]; *R v Joshi*, 2012 ONCJ 752, (2012), 104 WCB (2d) 765 (Ont Ct J); *R c Faucher*, 2013 QCCM 100, [2013] QJ no 4683 (CM) (QL); *R v McGrath*, 2013 ONCJ 528, (2013), 48 MVR (6th) 161. Ferguson argues that the objective standard of fault embedded in the *Chaulk* test is overly broad and may offend section 7 of the *Charter*, at least for offences that require proof of subjective *mens rea*; see Ferguson, *supra* note 54 at para. 6.

[59] RSC 1996, c 36.

[60] Isabel Grant, "Second Chances: Bill C-72 and the *Charter*" (1995) 33 Osgoode Hall LJ 379 at paras 12-13. See also Susan J Bondy, "Self-Induced Intoxication as a Defence in the Criminal Code of Canada: Issues and Discussion Around *Daviault v R*" (1996) 23 Contemporary Drug Problems 571 at 573-74; *House of Commons Debates*, No 177 (27 March 1995) at 11037 (Hon Allan Rock) [*Debates*].

> may be used socially and legally to excuse violence, particularly violence against women and children…

Conspicuously absent from that preamble is any mention of substance-associated psychoses, or any explanation as to how section 33.1 can operate without violating the *Charter* rights of accused persons as recognized by the majority in the *Daviault* case. With respect to the latter, Minister Rock stated in his address to Parliament that the decision of the Supreme Court of Canada in *Daviault* was not determinative of the constitutional question, as the Court did not have the benefit of the material evidence or full argument on the *Charter* issue.[61] He went on to express his own opinion that section 33.1 was likely to survive any *Charter* challenge.

Some legal commentators agree with Minister Rock's position.[62] Others take the opposite viewpoint.[63] Perhaps the only opinion shared among them is the certainty of a *Charter* challenge. In an article published shortly after the introduction of Bill C-72, Grant forecast that very outcome, stating that "it is virtually inevitable that Bill C-72 will make its way up to the Supreme Court of Canada, either by way of a constitutional reference or a Charter challenge by an accused denied the defence." As it turns out, Grant was somewhat optimistic in her prediction. The question of the constitutionality of section 33.1 has indeed been raised in various trial court proceedings. However, the Supreme Court of Canada has yet to render a decisive ruling on the issue. At this point in time, trial courts in British Columbia, Quebec and Nunavut have rendered decisions upholding section 33.1,[64] while others in Ontario and the Northwest Territories have declared the provisions to be unconstitutional.[65] In the result, accused persons face a varying and uncertain patchwork system of justice in Canada, in which cases of similar facts are likely to achieve wholly

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61 *Debates*, *ibid* at 11038-39.

62 See, *inter alia*, Grant, *supra* note 60; Kelly Smith, "Section 33.1: Denial of the Daviault Defence should be held Constitutional" (2000) 28 C.R. 5th 350.

63 See, *inter alia*, Ferguson, *supra* note 54; David Paciocco, "The Legacy of Daviault: Part I The Constitutionality of Bill C-72" (1995) 2 Sexual Offences L Rep 105; Heather MacMillan-Brown, "No Longer 'Leary' About Intoxication: In the Aftermath of *R v Daviault*" (1995) 59 Sask L Rev 312.

64 *Vickberg*, *supra* note 58; *Dow*, *supra* note 49; *R v SN*, 2012 NUCJ 2 (available on CanLII).

65 *R v Dunn*, [1999] 28 CR (5th) 295 (Ont Sup Ct); *Brenton*, *supra* note 58; *R v Jensen*, [2000] OJ No 4870 (Sup Ct) (QL); *R v Cedeno*, 2005 ONCJ 91, (2005), 195 CCC (3d) 468; *R v Fleming*, 2010 ONSC 8022, [2010] OJ No. 5988 (QL). *Cf. R v Decaire*, [1998] OJ No 6339 (Ct Just). See also Glen Luther, "Of Standing and Factual Foundations: Understanding How an Accused Challenges the Constitutionality of Criminal Litigation (2006) 51 CLQ 360.

different outcomes depending on the province or territory in which their case proceeds.

In the *Bouchard-Lebrun* case, the Supreme Court of Canada was asked to determine the effect of section 33.1 on the defence of NCRMD pursuant to section 16 of the *Criminal Code*.[66] To the disappointment of scholars, the Court did not also address the *Charter* issue, noting only that the appellant "raises no arguments" on the question, "which means that only the interpretation and application of that provision are in issue."[67] As Kaiser rightly notes, the Court's decision to proceed in this way, without consideration of the *Charter* argument, is tantamount to "osmotic constitutionalization."[68] Its reliance on section 33.1 might signal an underlying comfort with the provision, and foreshadow a future decision upholding it.[69] Nonetheless, this result cannot be assumed. A decisive ruling on the issue is needed, failing which discrepancies in the application of section 33.1 are likely to continue. Lower courts of different jurisdictions will no doubt continue to apply the law in different ways, to the extreme benefit of some accused persons and the extreme prejudice of others.

B) Defence of Not-criminally-responsible-by-reason-of-mental-disorder

1) Cooper Exclusion of Self-Induced Mental States from Reach of NCRMD Defence

Section 16 of the *Criminal Code* offers a statutory defence to accused persons who, by reason of a mental disorder, lacked the guilty mind required to support a conviction. It operates so as to exempt the accused person from criminal liability "on the belief that persons suffering from

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[66] *Bouchard-Lebrun*, *supra* note 8.

[67] *Ibid* at para 28; H Archibald Kaiser, "*Bouchard-Lebrun*: Unduly Limiting Toxic Psychosis and Reigniting the Dangerous Intoxication Debate" (2012) 89 CR (6th) 68. See also the Annotation by Donald Stuart, as cited in Coughlan *et al*, *supra* note 57 at 201. Other courts have similarly proceeded on the assumption that section 33.1 is constitutional without considering the *Charter* issue; see *R c Côté*, 2013 QCCQ 4485, [2013] QJ no 4843 (CQ (Crim & Pen Div)) (QL) [*Côté*]; *Wells*, *supra* note 56; *R v Weitzel*, 2004 BCSC 1767, (2004), 64 WCB (2d) 161; *R v BJT*, 2000 SKQB 572, [2001] 4 WWR 741; *R v Martin*, [1999] OJ No 5066 (CA) (QL); *R v Frechette* (1999), 132 CCC (3d) 1 (BCCA).

[68] Kaiser, *supra* note 67; Donald Stuart, "Vagueness, Inconsistency and Less Respect for *Charter* Rights of Accused at the Supreme Court in 2012-2013" (2013) 63 SCLR (2d) 441.

[69] Dennis Baker and Rainer Knopf, "*Daviault* Dialogue: The Strange Journey of Canada's Intoxication Defence" (2014) 19 Rev Const Stud 35.

insanity should not be subject to standard criminal culpability with its resulting punishment and stigmatization."[70] To hold otherwise, LeBel J wrote, would offend Canadian values:

> … [I]t can also be said that an insane person is incapable of morally voluntary conduct. The person's actions are not actually the product of his or her free will. It is therefore consistent with the principles of fundamental justice for a person whose mental condition at the relevant time is covered by s. 16 *Cr.C.* not to be criminally responsible under Canadian law. Convicting a person who acted involuntarily would undermine the foundations of the criminal law and the integrity of the judicial system.[71]

Consequently, if an individual successfully advances a defence under section 16, he will not be convicted. However, in Canada, that individual also will not be acquitted. Instead, the accused will be declared "not-criminally-responsible-by-reason-of-mental-disorder" (NCRMD) and, pursuant to the provisions of Part XX.1 of the *Criminal Code,* be diverted to the forensic psychiatric hospital system for so long as he or she poses a significant threat to public safety.[72] In the words of McLachlin J, "Throughout the process the offender is to be treated with dignity and accorded the maximum liberty compatible with [the] goals of public protection and fairness to the NCR accused."[73] This particular sentiment reflects the underlying view that NCR accused persons are not morally blameworthy for conduct that otherwise would be considered criminal.

The origins of the NCRMD defence can be traced to *M'Naghten's Case.*[74] M'Naghten was charged for the murder of Edward Drummond on January 20, 1843. He shot the deceased, mistakenly believing him to be the British Prime Minister, Sir Robert Peel, and under the delusion that Peel's government was persecuting him. It was argued by way of defence that M'Naghten suffered from a form of insanity which deprived him of the powers of self-control. The jury acquitted. Subsequently, the question of the availability of a common law defence of insanity became the topic of debate in the House of Lords. This debate culminated with the referral of five questions to the Law Lords about the elements of the defence. In his response to these questions, Lord Chief Justice Tindal held as follows:

> … [E]very man is to be presumed to be sane, and to possess a sufficient degree of reason to be responsible for his crimes, until the contrary be proved to their

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70 *Chaulk*, *supra* note 58 at paras 22, 95.

71 *Bouchard-Lebrun*, *supra* note 8 at para 51.

72 *Criminal Code*, *supra* note 6, s 672.54.

73 *Winko v British Columbia Forensic Psychiatric Institute*, [1999] 2 SCR 625 at para 43.

74 (1843), 8 ER 718 (HL).

> satisfaction; and that to establish a defence on the ground of insanity, it must be clearly proved that, at the time of the committing of the act, the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know he was doing what was wrong.[75]

The essential elements of this defence, as articulated by the Lord Chief Justice, were subsequently incorporated into Canada's first *Criminal Code*. It operated at that time so as to excuse an accused person who, by reason of a "natural imbecility" or "disease of the mind," was incapable of appreciating the nature and quality of his or her conduct and of knowing it was wrong.[76]

In 1992, section 16 of the *Criminal Code* was amended to its current form.[77] It now reads as follows:

> (1) No person is criminally responsible for an act committed or an omission made while suffering from a mental disorder that rendered the person incapable of appreciating the nature and quality of the act or omission or of knowing that it was wrong.
>
> (2) Every person is presumed not to suffer from a mental disorder so as to be exempt from criminal responsibility by virtue of subsection (1), until the contrary is proved on the balance of probabilities.
>
> (3) The burden of proof that an accused was suffering from a mental disorder so as to be exempt from criminal responsibility is on the party that raises the issue.[78]

Section 2 of the *Criminal Code* defines the term "mental disorder" to mean a "disease of the mind."[79] As LeBel J noted in *Bouchard-Lebrun*, this is a circular definition, and one that the courts have had to develop as a result.

Whether a particular condition is a "disease of the mind" is a question for determination by the trial judge. In making that determination, the court

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75 *Ibid* at 722.

76 *Criminal Code*, SC 1892, c 29, s 11. See Simon Verdun-Jones, "The Evolution of the Defences of Insanity and Automatism in Canada from 1843-1979: A Saga of Judicial Reluctance to Sever the Umbilical Cord to the Mother Country?"(1979) 14 UBC L Rev 1.

77 *Criminal Code*, *supra* note 6, s 16 as amended by SC 1991, c 43, s 2.

78 In *Chaulk*, *supra* note 58, the Supreme Court of Canada held this burden, when applied to the accused, infringes the presumption of innocence guaranteed by section 11(d) of the *Charter*. It is nonetheless saved by section 1.

79 *Criminal Code*, *supra* note 6, s 2.

will be informed by the evidence of medical and psychiatric experts[80] as well as public policy factors, such as the need to protect the public in circumstances where a particular mental disorder presents a risk of recurring danger on the part of the accused.[81] Such evidence may vary as between cases and evolve over time. As Dickson J noted in *R v Rabey*:

> What is disease of the mind in the medical science of today may not be so tomorrow. The court will establish the meaning of disease of the mind on the basis of scientific evidence as it unfolds from day to day. The court will find as a matter of fact in each case whether a disease of the mind, so defined, is present.[82]

As a result, it is incumbent on the party advancing the NCRMD application to tender the requisite evidence, and to persuade the trial judge to the applicable standard of proof on the basis of that evidence. Applicants cannot necessarily rely on earlier cases involving similar diagnoses. Theoretically, a condition previously excluded from section 16 may subsequently be recognized as a "disease of the mind" on the basis of new research. Likewise, a condition previously recognized as a disease of the mind may subsequently be excluded.

Generally speaking, however, the courts prefer a broad and liberal interpretation of the "disease of the mind" concept, restricted only in its definition by the exclusion of self-induced or transitory states. In the oft-cited case of *R v Cooper,*[83] Dickson J formulated the following definition:

> In summary, one might say that in a legal sense "disease of the mind" embraces any illness, disorder or abnormal condition which impairs the human mind and its functioning, excluding however, self-induced states caused by alcohol or drugs, as well as transitory mental states such as hysteria or concussion. In order to support a defence of insanity the disease must, of course, be of such intensity as to render the accused incapable of appreciating the nature and quality of the violent act or of knowing that it is wrong.[84]

It is important to note that the facts of the *Cooper* case did not include allegations of substance-induced psychosis or any other substance-related

80 *R v Parks*, *supra* note 50 at 989-99, adopting the reasons of Martin JA in *R v Rabey* (1977), 37 CCC (2d) 461 (Ont CA), aff'd [1980] 2 SCR 513 [*Rabey*].

81 *R v Stone*, [1999] 2 SCR 290 at para 212 [*Stone*].

82 *Rabey*, *supra* note 80 at 552.

83 [1980] 1 SCR 1149 [*Cooper*].

84 *Ibid* at 1159.

disorder. Consequently, Dickson's reference to self-induced intoxication is strictly *obiter*.[85]

Nonetheless, in reliance on the *Cooper* case, some Canadian courts excluded substance-induced psychosis from the purview of section 16 and refused the NCRMD defence on the basis that intoxication was voluntary on the part of the accused person. The decision of the New Brunswick Provincial Court in *R v Johnson* is one example.[86] In that case, the Court held that the accused was not eligible for the NCRMD defence, because substance-induced psychosis was excluded from the *Cooper* definition of disease of the mind "on policy grounds."[87] Curiously, however, in other cases, the courts took the opposite approach. For example, in *R v Snelgrove,* the BC Supreme Court applied section 16 without even considering the exclusion of substance-induced disorders from the *Cooper* definition.[88] In that particular case, it apparently did so with the agreement of the Crown.[89]

2) Potential for Expansion of NCRMD Defence through Bouchard-Lebrun Adoption of "More Holistic Approach"

Issues surrounding the scope of the *Cooper* definition, and the specific exclusion of substance-*induced* psychosis, came before the Supreme Court of Canada in the aforementioned *Bouchard-Lebrun* case.[90] The accused was charged with two counts of aggravated assault and assault, as well as breaking and entering with intent to commit a criminal offence and attempting to break and enter a place other than a dwelling house. Experts agreed that the accused was in a psychotic state at the time of the offences.

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[85] This definition of "disease of the mind" is consistent with the earlier decisions of the Ontario Court of Appeal in *Rabey*, *supra* note 80 and the English Court of Appeal in *R v Quick* (1973), 57 Cr.App R 722. In both cases, the courts similarly excluded self-induced intoxication from their definitions of disease of the mind. In the *Rabey* case, Martin JA added an important qualification at 55, stating expressly that this exclusion does not apply in cases "where alcoholic excess or drug abuse has brought about a disease of the mind."

[86] 2005 NBPC 40, [2005] NBJ No 585 (QL). See also *R v Moroz*, 2003 ABPC 5, (2003) 333 AR 109; *Paul*, *supra* note 5 at para 61.

[87] *Paul*, *ibid*. at para 30.

[88] *R v Snelgrove*, 2004 BCSC 102, [2004] BCJ No 120 (QL).

[89] See also *R v Hilton* (1977), 34 CCC (2d) 206 (Ont CA); *R v Mailloux* (1986), 25 CCC (3d) 171 (Ont CA), aff'd [1988] 2 SCR 1029; *R v Oakley* (1986), 24 CCC (3d) 351 (Ont CA); *R v Lauv*, 2004 BCSC 1093, (2004), 63 WCB (2d) 64; *R c Fortin*, 2005 CanLII 6933 (QCCQ); *R v DP*, 2009 QCCQ 644 [2009] QJ no 1252 (QL); *R c SL*, 2009 QCCQ 8166, [2009] QJ no 9410 (QL); *R v Baker*, 2009 ABCA 252, 246 CCC (3d) 520, aff'd [2010] 1 SCR 329.

[90] *Bouchard-Lebrun*, *supra* note 8.

They did not agree, however, on the etiology of the psychosis. The defence expert opined that the psychotic episode was triggered by a "mystical atmosphere" cultivated by the accused's companion, and that the accused's decision to use drugs on that occasion "was not made freely but was influenced in a way by the control his friend exercised over him."[91] The trial judge rejected that opinion, and instead accepted that of the Crown expert who testified the accused's psychosis resulted from substance use. The accused's particular mental state is described in the Court's judgment as "toxic psychosis." The accused was found to have consumed a combination of cannabis and amphetamines. He had no history of mental disorder.

At trial, on the basis of the evidence of intoxication, the trial judge acquitted the accused on charges of the specific intent offences of breaking and entering and attempting to break and enter. However, in relation to the charges against the accused of the general intent offences of aggravated assault and assault, the trial judge relied on section 33.1 of the *Criminal Code* to convict. The accused was sentenced to incarceration for a period of five years. The Quebec Court of Appeal dismissed the accused's subsequent appeal from both conviction and sentence, at which time the accused attempted unsuccessfully to advance the NCRMD defence. The accused then appealed to the Supreme Court of Canada. As set out above, the accused did not challenge the constitutionality of section 33.1. Instead, he argued two grounds of appeal relating to the interpretation of section 16 and its interplay with section 33.1, namely, the specific questions of whether section 33.1 limits the scope of the NCRMD defence, and whether toxic psychosis resulting from voluntary intoxication is a "mental disorder" for the purposes of section 16.

With respect to the first of these issues, the accused argued that section 33.1 ought not to be applied to section 16 so as to remove the NCRMD defence from the reach of those whose intoxication was self-induced. LeBel J agreed.[92] He nonetheless acknowledged that particular evidentiary challenges arise in cases of co-occurring substance use and mental disorder, where the etiology of a psychotic episode may be uncertain:

> If the accused was intoxicated and in a psychotic condition at the material time, the problem the court faces is to identify a specific source for his or her mental condition, namely self-induced intoxication or a disease of the mind, and determine whether it falls within the scope of s. 33.1 or s. 16 Cr. C. This appears to be all the more difficult to do in cases in which the mental health of the accused was already precarious prior

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91 *Ibid* at para 13.

92 *Ibid* at paras 36-37.

> to the incident in question, even if his or her problems had not yet been diagnosed at the time, and in which the psychosis emerged while the accused was highly intoxicated.[93]

LeBel J went on to say that "this identification of the source of the psychosis plays a key role, since it will ultimately determine whether the accused will be held criminally responsible for his or her actions."[94] He noted the obvious relationship between the mental states excluded from the *Cooper* definition, by reason of the fact that they were induced by alcohol or drugs, and those included in the scope of section 33.1. LeBel J held that, in such cases, trial judges should first determine the NCRMD application, and rely on section 33.1 only if section 16 is found not to apply.[95]

The question thus arises as to the circumstances in which an episode of substance-*induced* psychosis might cross the categorical divide from a state of intoxication to a condition of mental disorder within the meaning of section 16 of the *Criminal Code*. This was the second ground of appeal. Defence counsel, perhaps limited by the shortcomings of the evidentiary record and the lack of medical evidence on the various means by which psychosis can emerge in association with substance use, attempted to draw a hard line, arguing that toxic psychosis is "always" a disease of the mind. LeBel J rejected this argument. Doing so, he wrote, would effectively result in verdict-by-diagnosis. He found that the circumstances in which toxic psychosis could result are "heterogeneous,"[96] and that the automatic inclusion of toxic psychosis within the definition of disease of the mind would be inappropriate as a result. Interestingly, the Court did not rely on medical evidence for this particular finding of fact. Instead, it looked to prior case law:

> An additional reason for rejecting the appellant's central argument has to do with the very diverse reality encompassed by the term "toxic psychosis". In the case law, this term usually refers to the symptoms of the accused as diagnosed by psychiatrists. However, medical science does not always identify the causes of toxic psychosis as precisely as is required in law. Although toxic psychosis is always related to exposure to a toxic substance, the circumstances in which it may arise can vary a great deal. This is readily apparent from a review of the case law on this point. (see *R. v. Oakley* (1986), 24 C.C.C. (3d) 351 (Ont. C.A.); *R. v. Mailloux* (1985), 25 C.C.C. (3d) 171 (Ont. C.A.), aff'd [1988] 2 S.C.R. 1029; *R. v. Moroz*, 2003 ABPC 5, 333 A.R. 109; *R. v. Snelgrove*, 2004 BCSC 102 (CanLII); *R. v. Lauv*, 2004 BCSC 1093 (CanLII); *R. v. Fortin*, 2005 CanLII 6933 (C.Q.); *R. v. Paul*, 2011 BCCA 46, 299 B.C.A.C. 85).

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93 *Ibid* at para 38.

94 *Ibid*.

95 *Ibid* at para 40.

96 *Ibid* at para 68.

> Many factors might contribute to a state of substance-induced psychosis, including the fact that symptoms of a paranoid personality disorder are active at the time drugs are taken (*Mailloux*), the combined effect of exposure to toxic vapours and a period of intense stress (*Oakley*), dependence on certain drugs, such as cocaine (*Moroz* and *Snelgrove*), heavy drug use during the days and hours leading up to the commission of the crime (*Lauv* and *Paul*), and withdrawal following a period of excessive drinking (*R. v. Malcolm* (1989), 50 C.C.C. (3d) 172 (Man. C.A.)). It seems that this diversity of circumstances can be attributed to variations in psychological makeup and psychological histories from one accused to another, as well as in the nature of the drug use that contributed to their psychoses. The quantity and toxicity of the drugs taken also seem to have a significant effect in this regard. As a result, in each new situation, the case turns on its own facts and cannot always be fitted easily into the existing case law.[97]

Given the many factors that might cause or contribute to the onset of psychosis in association with substance use, the Court endorsed a "contextual approach" to the specific question of whether the accused person's psychosis is a product of intoxication or a disease of the mind for the purposes of section 16.[98] LeBel J recommended the following framework of analysis:

> When confronted with a difficult fact situation involving a state of toxic psychosis that emerged while the accused was intoxicated, a court should start from the general principle that temporary psychosis is covered by the exclusion from *Cooper*. This principle is not absolute, however: the accused can rebut the presumption provided for in s. 16(2) *Cr. C.* by showing that, at the material time, he or she was suffering from a disease of the mind that was unrelated to the intoxication-related symptoms.[99]

Regrettably, LeBel J did not define "temporary psychosis." It would appear from the language in this excerpt that "temporary psychosis" was considered by the Court to be a symptom of intoxication alone.

LeBel J also did not specifically address circumstances of potentially co-occurring or co-contributing mental disorder. He did, however, adopt the application of the "more holistic approach" described by Bastarache J in *R v Stone*, ruling that it ought to be followed by trial courts when assessing whether an accused discharged the burden of proof under section 16.[100] The *Stone* framework requires the court to consider whether the accused's condition is a product of internal or external factors, and whether the accused represents a continuing danger by reason of that condition.

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97 *Ibid* at paras 66-67.

98 *Ibid* at para 68.

99 *Ibid* at para 69.

100 *Ibid*.

Subject to any overriding policy considerations, those conditions which are attributable to external triggers, and which are not likely to recur independently, will generally fall outside the purview of section 16. As set out above, in *Bouchard-Lebrun*, the evidence established as a matter of fact that the accused's psychosis resulted from substance use.[101] It did not show, nor did the accused claim, that his psychotic episode was triggered by a latent, co-occurring disease of the mind. In the result, the circumstances of the case pointed to the drugs consumed by the accused as the specific external factor leading to psychosis. There was no evidence of any internal causal factor. There also was no evidence to suggest that the accused was inherently dangerous. On the contrary, he posed no threat to public safety so long as he abstained from further drug use. LeBel J noted, however, that the accused did not suffer from any drug dependence and that he might have reached a different conclusion in those circumstances.[102] Nonetheless, given the facts at bar, the Court did not consider it necessary to resort to the protective scheme provided for in Part XX.1 of the *Criminal Code*. Those provisions, LeBel J wrote, are not intended to apply to "accused persons whose temporary madness was induced artificially by a state of intoxication."[103] Accordingly, the Court concluded that the accused was not eligible for the defence of NCRMD.

LeBel J was alert to the possibility of more complex facts emerging in subsequent cases. He cited, by way of example, circumstances in which an accused person presents with an underlying mental disorder, but nonetheless had consumed substances of a nature and quantity that could produce psychosis in a normal person. In such cases, LeBel J advised, the courts should be "especially meticulous" in applying the "more holistic approach" articulated in *Stone*.[104] It remains to be seen how the courts will apply this approach in response to evidence of underlying neurobiological factors that might have contributed to the onset of psychosis in association with substance use. Only a modest number of reported decisions on this question are now available.[105] However, it is clear that, through the portal of the more holistic approach, substance-associated psychosis may well be drawn into the scope of section 16. In light of the findings of the Supreme Court of Canada in *Bouchard-Lebrun,* one should expect that the courts will – at the very least – give consideration to any evidence of the role that mental disorder or neurobiological vulnerability played in the onset of the

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[101] *Ibid* at para 24. *C.f. R v Lesann*, 2014 SKQB 332, (2014), 445 Sask R 1.

[102] *Bouchard-Lebrun*, *supra* note 8 at para 83.

[103] *Ibid* at para 84.

[104] *Ibid* at para 88.

[105] See, *inter alia*, *Côté*, *supra* note 67; *R v Cramer*, 2014 BCSC 1166, [2014] BCJ No 1323 (QL).

psychotic episode, as well as the risk of relapse on the part of the individual accused in light of these frailties.[106]

4. Issues for Future Cases

A) Need to Resolve the Constitutional Questions Surrounding Section 33.1, and Consider Development of Alternate Offences for Acts of Criminal Intoxication

It is difficult to predict the outcome of any future challenge to section 33.1 of the *Criminal Code*. What is clear, however, is that the factual matrix underlying the historic *Daviault* decision, and the stated justifications for section 33.1, are now very much in doubt. In the case of *Dow*, the Quebec court found as a matter of fact that extreme-intoxication-akin-to-automatism is a psychiatric fiction disproved by modern science.[107] Unfortunately a comprehensive assessment of the *Charter* argument, considered in the specific circumstances of substance-associated psychosis as compared to extreme intoxication in the form before the Court in *Daviault*, is outside the scope of this analysis. Suffice to say at this point that much will surely turn on the evidence adduced by the parties in relation to the nature and quantity of the substances in question, the correlation between usage of psychogenic substances and subsequent violence, and the specific *mens rea* requirements of the offences for which the accused is charged.

One can also reasonably expect that the court will give due consideration in the course of any *Charter* challenge to the alternate means by which Parliament could achieve the objectives of section 33.1. In the cases of *R v Penno* and *Daviault,* the Supreme Court of Canada discussed – albeit only in passing – the creation of a new offence for those who engage in harmful behaviour as a result of wilful, reckless, or negligent intoxication.[108] The Law Reform Commission of Canada previously recommended the development of such an offence in 1982.[109] Similar

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[106] In *R v Clough*, [2010] QCA 120, the Queensland Court of Appeal adopted a strict and narrow approach to the question of criminal responsibility in cases of co-occurring mental disorder and substance use. It interpreted the relevant provisions of the *Criminal Code* so as to hold that accused persons are liable for acts or omissions committed as a result of the effects of the intentional intoxication, including the manifestation of the symptoms of an underlying primary psychotic disorder or the relapse of such condition. See Russ Scott, "Amphetamine-Induced Psychosis and Defences to Murder" (2012) 15 Psychiatry, Psych & L 615.

[107] *Dow*, *supra* note 49.

[108] *R v Penno*, [1990] 2 SCR 865 at para 85; *Daviault*, *supra* note 48 at para. 56.

[109] Law Reform Commission of Canada, *Criminal Law*, *The General Part: Liability and Defences* (Working Paper 29) (Ottawa: Ministry of Supply and Services Canada, 1982). See also Ferguson, *supra* note 54; Paul B Schabas "Intoxication and

recommendations were included in, *inter alia,* the 1975 Report of the UK Committee on Mentally Abnormal Offender.[110] The offence reportedly exists already in Germany and parts of common law Africa.[111] Prior to the enactment of Bill C-72, one public bill was introduced into the Senate, and two private members' bills were introduced in Parliament, all of which proposed that the *Criminal Code* be amended to include this offence. Bill S-6[112] and Bill C-303[113] proffered an offence of "dangerous intoxication." The latter invoked the notwithstanding clause in section 33 of the *Charter*, by specifying that the new offence provisions would "operate notwithstanding sections 2 and 7 to 15 of the *Charter*." Bill C-305, which was introduced subsequently, proposed the creation of an offence of "voluntary intoxication."[114] It excluded any reference to the notwithstanding clause, presumably on a changed view that the proposed legislation would be *Charter* compliant.[115]

Neither of these private members' bills proceeded beyond first reading in the House of Commons. Instead, the Liberal Government lent its support to Bill C-72. Minister Rock explained his government's reasons as follows:

> The first reason was the penalty. Clearly, it was the view of the government that if there was to be accountability in the criminal law, then the maximum penalty for any new offence of criminal intoxication would have to be the same as the maximum penalty for the original offence. Otherwise, we have the spectre of having created a drunkenness discount which would give people who intoxicate themselves an option to have a lesser penalty for the same crime. That obviously is unacceptable. ...

Culpability: Towards an Offence of Criminal Intoxication" (1984) 42 UT Fac L Rev 147; Tim Quigley, "Reform of the Intoxication Defence" (1987) 33 McGill LJ 1; and Andrea Onn, "Self-Induced Intoxication: Balancing Principles of Justice and Responsibility" (1996) 23(4) Contemporary Drug Problems 687. *C.f.* Bondy, *supra* note 60.

[110] See Articles 18.51-18.59 of Secretary of State for the Home Department & Secretary of State for Social Services, *Report of the Committee on Mentally Abnormal Offenders* (London, UK: Her Majesty's Stationery Office, 1975) for a considered formulation of the proposed offence.

[111] Benedikt Fischer and Jurgen Rehm, "Alcohol Consumption and the Liability of Offenders in the German Criminal System" (1996) 23(4) Contemporary Drug Problems 707.

[112] Bill S-6, *An Act to amend the Criminal Code (dangerous intoxication)*, 1st Sess., 35th Parl., Canada, 1994-96.

[113] Bill C-303, *An Act to amend the Criminal Code (dangerous intoxication)*, 1st Sess., 35th Parl., Canada, 1994-95.

[114] Bill C-305, *An Act to amend the Criminal Code (voluntary intoxication)*, 1st Sess., 35th Parl., Canada, 1994-95.

[115] See also *Debates*, *supra* note 60 at 11040, wherein Minister Rocks references a similar bill reportedly introduced in the Senate.

> The second reason for not pursuing the option of creating the criminal intoxication offence related to the labelling of the offence. … The government believes that a person who becomes voluntarily intoxicated to the point of losing conscious control or awareness and in that state causes violence to another person is at fault for the assault and should be held criminally accountable for that offence and for nothing less.
>
> …
>
> Third, a detailed examination of the criminal intoxication option in its various forms established that many of the charter [sic] and legal theory problems identified by the Supreme Court in relation to the common law rule as it applies to basic intent would apply with almost as much force to any such new offence.
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> …
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> Last, the prospect of the charge of criminal intoxication raised the spectre of the prosecuting crown attorney being required to argue contradictory positions at trial. One position would be that the person was not so intoxicated as to escape responsibility but in the alternative the person was intoxicated and therefore should be convicted of criminal intoxication.[116]

Minister Rock went on to say that his government examined the option of amending the charging provisions for criminal negligence to include self-induced intoxication, but rejected it because "[i]t avoided accountability for the central misconduct and provided a lesser label for the underlying harm which we believe should be addressed directly."[117]

Minister Rock's reasons reflect a relatively simplistic view of substance use, and one which appears to overlook entirely the complexities that reportedly arise in cases of co-occurring and co-contributing mental disorder, not to mention the compromised volitional capacity of those struggling with substance dependence. His reasons seem to centre more on procedural and legal aesthetics than on substantive rights and meaningful remedies. It is doubtful whether the *Charter* issues that Minister Rock anticipated in relation to the new offence would be any less controversial than those presently at issue in relation to section 33.1. Minister Rock emphasized in this passage, and later in his address, the significance of accountability on the part of the offender for any offences committed while intoxicated. Surely the creation of a new offence – however called or prosecuted – could achieve just that in a more appropriate and measured way by marrying the *mens rea* of criminal intoxication with a corresponding *actus reus*. Architects of that law would be wise to consult the recent work

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[116] *Ibid* at 11037-38.

[117] *Ibid* at 11038.

of Ferguson, in which he proposes the enactment of offence provisions grounded in the legal framework of penal negligence.[118]

B) Need to Ensure Access to Material Evidence, Including Disclosure by Experts of Diagnostic Uncertainty and Potential Instability

Bastarache J rightly observed in the *Stone* case that courts are often required to proceed on the basis of imperfect evidence.[119] In cases involving allegations of substance-associated psychosis, where a determination of mental state must be made, the court may have little more before it than the version of events reported by the accused, and the subjective opinion of the assessing psychiatrist based on that singular version of events and an otherwise limited diagnostic process.[120] In these cases, there is a risk that accused persons could end up with wrongful convictions – or wrongful declarations of NCRMD – not because of a lack of underlying mental infirmity, but due to both imperfect and *insufficient* evidence on that very question.[121]

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118 Ferguson, *supra* note 54 at 116, where the author supports the recognition of a *lessened inhibitions defence of involuntary intoxication*, pursuant to which the accused would be acquitted if, "his or her ordinary volitional control mechanisms are impaired, through no relevant fault of his or her own, to the extent that the accused has committed an offence which he or she would not have committed if sober."

119 *Stone*, *supra* note 81 at para186.

120 Potentially, the reports of an accused person might not only be self-serving, but also incomplete; see *R v OV*, 2013 BCSC 52 at para 40, [2013] BCJ No 57 (QL), where the defence expert noted his "ability to comment on the [accused's] mental state is limited by [the accused's] inability to recall the acts with which he is charged…and was further confounded by his inconsistency as a historian, when viewed within the context of limited collateral information."

121 This risk is particularly acute for adolescent accused persons who may lack the clinical history on which psychiatrists rely in rendering their diagnoses. Indeed, this is a risk that apparently materialized in prior years, when the psychoactive effects of intoxication by crystal methamphetamine were not well known or easily distinguishable from symptoms of primary psychotic disorders. One might imagine that these limitations could one day be overcome – or at least ameliorated - by the use of neuroimaging techniques, the results of which might assist psychiatrists in identifying the etiology of psychosis and the impact of mental disorder on the accused's decision-making process; see Gerben Meynen, "A Neurolaw Perspective on Psychiatric Assessments of Criminal Responsibility: Decision-Making, Mental Disorder, and the Brain" (2013) 36 Int'l J L & Psychiatry 93. For an example of research on first-episode psychosis using magnetic resonance imaging technology, see Anne Ruef *et al*, "Magnetic Resonance Imaging Correlates of First-Episode Psychosis in Young Adult Male Patients: Combined Analysis of Grey and White Matter" (2012) J Psychiatry Neurosci 1. However, Chandler found that, although Canadian courts are increasingly considering neuroscientific evidence in criminal cases, it mainly pertains to sentencing decisions. In addition, Chandler suggests that neuroimaging techniques have yet to become accepted in Canadian courts. See

In such cases, and in order to mitigate the risk of perverse verdicts, it is essential that the court and the parties have access to all material evidence concerning diagnosis, including information with respect to diagnostic process as well as the seemingly abundant literature on issues of diagnostic uncertainty and instability. Disclosure of this nature is particularly important in an era of constrained legal aid budgets, where defence counsel might not be able to pay for consultations with an independent expert and consequently are disadvantaged in their ability to test a psychiatric assessment in court.

In appropriate cases, counsel also may consider procedural steps and strategies that result in the deferral of the ultimate hearing to allow time for longitudinal assessment. It is not clear how long might be required in any given case. As Watts suggests, if sufficient mental health resources are not allocated to the long-term follow up of individuals who are initially diagnosed with a substance associated psychotic state, it is possible that the courts will fail to identify those among them whose symptoms actually constitute the early manifestation of a persistent psychotic state:

> … an accused might offer a plea of insanity without any evidence of psychiatric care after the offense and during their pretrial detention. This scenario is especially possible for individuals evaluated while in jails that have little psychiatric infrastructure. They are likely to be lost to follow-up, especially if their symptoms, marked by negative symptoms and lack of insight, resume a milder course in the absence of drugs. It is entirely possible that such individuals, for whom a substance-induced psychosis is in fact the first presentation of a chronic psychotic illness, may miss the opportunity to avail themselves of an insanity verdict.[122]

No doubt the length of the period of delay necessary before bringing a case to an ultimate determination of the NCRMD issue will vary depending on the particulars of the accused person's condition and circumstances in the post-assessment period. The diagnostic process may be thwarted by, for example, continued substance use.[123]

Jennifer A Chandler, "The Use of Neuroscientific Evidence in Canadian Criminal Proceedings" (2015) J L & Biosciences 1.

122 Watts, *supra* note 25 at 381.

123 Presumably any delay sought by the defence for this purpose would not be attributed to the Crown, and would not put the case at risk of a subsequent challenge based on delay pursuant to section 11(b) of the *Charter*; see *R v Askov*, [1990] 2 SCR 1199; *R v Morin*, [1992] 1 SCR 771. In the result, one would not expect that the Crown would oppose an adjournment sought for these reasons, so long as public safety was properly protected during the pre-trial period and the evidence required for trial otherwise preserved.

C) Need to Challenge Perverse Verdicts Based on Erroneous Diagnoses

In those cases where the diagnosis accepted by the court is subsequently determined to have been erroneous, an accused person may challenge the resulting wrongful conviction or declaration of NCRMD.[124] The accused in *R v Evans* did just that.[125] He was charged with robbery and possession of a dangerous weapon arising from an incident that occurred in March 2005. The assessing psychiatrist concluded that the accused suffered from schizophrenia, poly-substance abuse, and anti-social personality disorder. At his trial in August 2005, the accused admitted to the robbery and, on the strength of the psychiatric opinion, consented to a declaration of NCRMD. The Crown did not proceed with the weapons charge.

It was subsequently determined that the accused did not suffer from schizophrenia, and that the more appropriate diagnosis was substance-induced psychosis. Despite a series of expert opinions to this effect produced between 2007 and 2011, and notwithstanding evidence that the accused was functioning well without medication, the Ontario Review Board refused to grant a discharge. At the time of his appeal, the accused had been in custody for more than seven years. At the request of counsel for the accused, the Court of Appeal agreed to reopen the case, and allow the new medical evidence to be admitted. On that appeal, the accused argued that the NCRMD verdict was a miscarriage of justice and that he ought to have been convicted instead. The Court of Appeal agreed. SE Pepall JA, writing for the Court, held as follows:

> In this case, the appellant was found to be NCRMD on the basis that he suffered from schizophrenia. That diagnosis has been ruled out by the appellant's treatment team. Additionally, Dr. Komer has testified that the "best fit" for the appellant at the time of the offence was a substance-induced psychosis. The respondent concedes that a self-induced substance-induced psychosis would not support an NCRMD finding. In these circumstances, the NCRMD verdict cannot be sustained and should be set aside. It amounts to a miscarriage of justice.[126]

[124] In those cases where appeal rights have expired, the accused person may apply for an extension of the time periods in which an appeal may be brought; see *Court of Appeal Act*, RSBC 1996, c 77, s 10(1) ; *Supreme Court Act*, RSC 1985, c S-26, ss 40(4) and 59(1). In BC, in those cases where an appeal has not been heard on the merits but has been dismissed for want of prosecution, the Court of Appeal may exercise its inherent jurisdiction to reopen the appeal if the interests of justice so require. See *R v Henry*, [1997] 100 BCAC 183. Otherwise, discretionary remedies are available from the Minister of Justice of Canada pursuant to the provisions of Part XXI.1 of the *Criminal Code*.

[125] 2012 ONCA 412, (2012), 294 OAC 63.

[126] *Ibid* at para 15.

The Court of Appeal substituted a conviction and sentenced the accused to one day in custody, noting that the seven years spent by the accused in detention was "outside the range of any sentence he would have received had he pled guilty to the robbery charge in August 2005."[127]

This case illustrates the hardship and prejudice that can flow to accused persons who are declared NCRMD on the basis of an erroneous diagnosis. It showcases the inherent limitations of forensic psychiatry, particularly in cases of substance associated psychosis. However, it stands now also as a compelling precedent which other courts might follow in remedying miscarriages of justice, whether by way of wrongful declaration of NCRMD or wrongful conviction. Indeed, it is open to offenders to make a similar argument to that advanced in *Evans* in circumstances where an erroneous diagnosis resulted in a conviction rather than a declaration of NCRMD. Hardship and prejudice might arise in equal measure if an accused is wrongfully denied an NCRMD application, particularly if the sentence imposed on that accused is for a significant period of time and the accused is otherwise amenable to treatment.

D) Need to Test Evidence of Addiction (and Other Co-occurring Mental Disorders)

It is through the portal of the "more holistic approach" that section 16 may be expanded to capture conditions of co-occurring and co-contributing substance use (even if voluntary) and mental disorder. As noted above, in his judgment in *Bouchard-Lebrun,* LeBel J specifically noted that the *Cooper* exclusion might not apply to the addict population. It is incumbent on counsel to now test the impact of evidence of co-occurring mental disorder on the assessment of criminal responsibility and, in particular, the availability of the defence of NCRMD where intoxication was influenced by substance dependency on the part of the accused. As LeBel J observed, in the latter cases, there may be continuing danger to the public if the accused person is at risk of relapse as a result of his or her addiction. That fact alone may tilt in favour of a finding of NCRMD.

There is some support for this argument in the work of the National Institute on Drug Abuse. This organization takes the view that addiction is a "brain disease" and that, while the initial decision to take a substance may be voluntary, the disease itself renders continued drug use by the addict entirely involuntary.[128] It is important to note, however, that this

[127] *Ibid* at para 18.

[128] National Institute on Drug Abuse, *The Science of Addiction: Drugs, Brains, and Behavior*, online: National Institute on Drug Abuse <http://www.nida.nih.gov /scienceofaddiction/sciofaddiction.pdf>.

view is not universally endorsed. It is the position of some scholars that, however vulnerable an individual might be to the onset of addiction, and however strong that individual's internal compulsions might be for continued use, he or she still has the *experience of choosing*.[129] In this way, addiction is characterized as an experience analogous to duress, wherein the individual faces a hard choice, but a choice nonetheless.[130] An individual may be predisposed to addiction and to relapse, but he or she nonetheless is "not an automaton, responding mindlessly to environmental cues."[131] For this reason, addiction-motivated behaviour is perhaps better described as a condition of volitional impairment and not one of true involuntariness.[132]

The key question for the court in future cases involving substance dependence might be whether the degree of volitional impairment was such that intoxication could no longer be characterized as "self-induced" and the consequent episode of psychosis thus attributable to an internal factor. As a matter of fact, was the accused in a position to exercise a sufficient degree of self-control in relation to future use, and thus mitigate the risk of continuing danger of relapse through self-restraint? As a matter of policy, the courts may prefer not to exempt accused persons from criminal responsibility unless the degree of volitional impairment is grave. Otherwise, the court would be further expanding the NCRMD beyond its statutory confines, and effectively exempting accused persons from criminal responsibility even if their conduct was not wholly involuntary. On the other hand, where the risk of relapse is significant, the administration of justice may be better served through treatment in the forensic psychiatric system, where there is potential for ongoing supervision. Doing so is more consistent with a medical model in the treatment of addiction as a disease and not a failing of the will. If the court elects to take this course, however, provincial governments must be prepared to respond with the resources needed to accommodate the diversion of this population from the correctional system to the forensic psychiatric system.

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[129] See, *inter alia*, Richard J Bonnie, "Responsibility for Addiction" (2002) 30 J Am Acad Psychiatry L 405; Herbert Fingarette, "Addiction and Criminal Responsibility" (1975) 84(3) Yale LJ 413; and Gene Heyman, "Addiction and Choice: Theory and New Data" (2013) 4 Frontiers in Psychiatry 31.

[130] *Bonnie*, *ibid* at 407.

[131] *Ibid*.

[132] *Ibid*; see also William G Campbell, "Addiction: A Disease of Volition Caused by a Cognitive Impairment" (2003) 48 Can J Psychiatry 669.

5. Conclusion

It is apparent from the reported case law that, historically at least, there has been a disconcerting variation in approach to the treatment of accused persons in circumstances of substance associated psychosis. So significant is the variation that opposite outcomes have emerged in cases with relatively similar facts. Perhaps the most striking legal factor at play in these cases is the manner in which Canadian courts have interpreted and applied sections 16 and 33.1 of the *Criminal Code*. The latter provision is particularly controversial, as it allows the Crown to rely on the *mens rea* of voluntary intoxication to prove the *mens rea* elements otherwise required for conviction. Not surprisingly, some courts have declared the provision to be unconstitutional. Others have upheld it, largely in reliance on normative perspectives on the moral blameworthiness of substance use. Yet other courts have applied section 33.1 without considering the *Charter* issue. In the result, accused persons in Canada have received – and will undoubtedly continue to receive until this issue is finally resolved – contradictory outcomes depending largely on the jurisdiction in which their case proceeds. Historically, there has been a similar discrepancy in the interpretation and application of section 16 of the *Criminal Code,* with some courts granting the NCRMD defence in cases of substance-induced psychosis and others excluding the condition on policy grounds. The decision of the Supreme Court of Canada in *Bouchard-Lebrun* brings much-needed clarification to this area of the law. One might reasonably expect, in reliance on this case, that section 16 applications will be denied in future proceedings where psychosis is found to have resulted *exclusively* from substance use.

It is not clear whether the courts will apply with equal consistency the "more holistic approach" prescribed in *Bouchard-Lebrun*. That issue will undoubtedly be decided on a case-by-case basis, given the heterogeneity of substance-associated psychoses. The most significant forensic factor contributing to outcome in these cases will certainly be the nature and quality of the expert psychiatric evidence. The central determinant of the defenses available at trial, and disposition on conviction or declaration of NCRMD, is the etiology of the psychotic episode experienced by the accused person at the time of the offence. In cases where psychosis manifests in association with substance use, however, etiology can be elusive and enigmatic. It is not even clear that psychiatric and neuroscientific research is sophisticated enough at this point in time to allow for the identification of these factors and the measurement of their relative impact. This is an area of forensic medicine – and a question of law – in need of further investigation. It likewise is not known what underlying neurobiological factors, and what degree of impairment, might be found to

justify an exemption from criminal responsibility on the application of the "more holistic approach" to section 16 of the *Criminal Code.* At most, existing research supports the re-conceptualisation of causation from one of inducement to one of association, but it falls far short of supporting any radical restructuring of the framework of criminal liability.

Arguably, in the absence of any reliable *science of fault* in cases of voluntary intoxication, the courts have little choice but to accept the crude assumptions of rational choice for operational purposes. It cannot be said that guilt-by-proxy – either in principle and as expressed in section 33.1 of the *Criminal Code* – is obviously right or obviously wrong. It is based on one normative perspective, and represents but one approach to the problem of proving *mens rea* in cases of voluntary intoxication. The proposed offence of criminal intoxication offers another. The *Cooper* exclusion of substance-induced mental states from the purview of section 16 constitutes a further approach to the attribution of criminal responsibility. Any expansion of that defence to include cases of co-occurring mental disorder (including addiction) or neurobiological vulnerability (including genetic predisposition) would embody yet another. Canadian law must await further cases in which courts can consider these alternatives in the specific context of substance-associated psychosis and in light of the emerging research. That should not take long. Carroll et al. describe substance-induced psychosis as a phenomenon of "epidemic" proportions.[133]

Until then, however, law and policy makers might be inspired to shift the focus of this debate from considerations of culpability to concerns of public safety. After all, criminal law is premised on principles of *fault* and *harm.*[134] The fault principle supports criminal sanction if the actor is culpable. However, it does not stand alone. It operates in concert with the

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133 Carroll *et al*, *supra* note 11 at 637. The BC Centre for Excellence in HIV/AIDS use the same language to describe the drug situation in Vancouver. One might expect these cases to surface in growing numbers in British Columbia, given the reported increase in the popularity of psychoactive substances among drug users. See Urban Health Research Initiative of the British Columbia Centre for Excellence in HIV/AIDS, *Drug Situation in Vancouver* (October 2009), online: <http://uhri.cfenet.ubc.ca/images/Documents/dsiv2009.pdf>.

134 See, *inter alia*, Stephen J Morse, "Craziness and Criminal Responsibility" (1999) 17 Behav Sci L 147; David Ormerod, *Smith and Hogan Criminal Law: Cases and Materials*, 10th ed (Oxford: Oxford University Press, 2009); Gerben Meynen, "Should or Should Not Forensic Psychiatrists Think About Free Will?" (2009) 12 Med Health Care and Philos 203. For a discussion of these principles in relation to psychopathy, see Charles Fischette, "Psychopathy and Responsibility" (2004) 90 Va L Rev 1423; Stephen D Hart, "Psychopathy, Culpability and Commitment" in Robert F Schopp *et al*, eds, *Mental Disorder in Criminal Law: Responsiblity, Punishment and Competency* (New York, NY: Springer, 2009).

harm principle. That principle supports the criminalization of behaviour that is inherently harmful *and the detention of offenders for so long as they pose a threat to public safety*. Regardless of the degree of fault that may be attributable to an accused person, questions arise as to whether – as a matter of policy – cases of substance-induced psychosis should be managed in the forensic psychiatric system or the correctional system. Is the public interest served by relatively short periods of incarceration in the correctional system where opportunities for treatment are limited? Is it better served within the forensic health system, even though tenure in that system may be prolonged and uncertain? For now, some comfort may be taken from the knowledge that the proverbial doors of justice are at least open, on the application of the "more holistic approach" articulated in *Bouchard-Lebrun*, to receiving evidence of co-occurring and potential co-contributing substance use and mental disorder. Indeed, one would expect courts to give due regard to such evidence, but hope also that they exercise appropriate care and caution both in the context of each particular case and in shaping the development of the law itself. It is apparent from this study that the imperfections of science can produce perverse verdicts in any given case. These same imperfections can lead to gross injustice if relied on further for far-reaching reform.