A Tough Pill to Swallow: Criminal Culpability Arising From an Avoidable NCR State

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"Crimes are not to be measured by the issue of events, but by the bad intentions of men."
- Cicero[1]

I. INTRODUCTION

The *Criminal Code of Canada*[2] formally sets out the defence available to an accused who was mentally disordered at the time he or she committed a crime. The premise that the mentally disordered ought not to be held responsible for their moral and legal transgressions is not new. It has been both a long-standing principle of moral philosophy[3] and accepted legal doctrine since ancient times.[4] Formerly the "insanity defence", the legal defence on which the mentally disordered may rely is now referred to as "not criminally responsible on account of mental disorder" (NCR).[5]

The benefit of the doubt is given to one who commits a crime while mentally disordered, insofar as he or she is legally presumed to have had no bad intention. Is this lack of bad intention necessarily true in all cases? What if the person let his or her mental disorder worsen, despite being able to prevent it, and this precipitated a violent crime? Might there have been "bad intention" in that case? By neglectfully or intentionally causing his or her mental illness to deteriorate, does he or she thereby commit an offence known to the law? If not, should such

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1 John Bartlett, ed, *Familiar Quotations*, 13th ed (New York: Little, Brown and Company, 1955) *sub verbo* "Cicero".

2 *Criminal Code*, RSC 1985, c C-46 [*Criminal Code*].

3 Aristotle, *Nicomachean Ethics Book III*, translated by WD Ross (Greece: 350 BCE), online: Massachusetts Institute of Technology <http://classics.mit.edu/Aristotle/nicomachaen.html>.

4 Babylonian Talmud, *Bava Kama*, 87a.

5 *Criminal Code*, *supra* note 2 at s 16. See also *R v Trueman*, (1992) 80 Man R (2d) 72, where the recently amended NCR defence (as opposed to the "insanity defence") was first utilized in Manitoba.

an offense be created? If so, what level of culpability should attach to him or her? This article will address each of these questions in turn.[6]

The Manitoba case of Paul Joubert[7] illustrates a scenario where the above questions perhaps ought to have been addressed. Joubert's troubles with mental illness began in 1999 when he sought treatment at an emergency department, complaining that his father had poisoned him. He was given stomach medication and sent on his way. Six months later his parents had him involuntarily assessed for psychiatric illness. Joubert's delusions that his parents were poisoning his water had persisted and worsened to the point that he was making death threats against them. Joubert was diagnosed as suffering from chronic schizophrenia, paranoid type. After three weeks of medication and therapy, Joubert seemed willing to adhere to his medication and was discharged after agreeing to follow up with his physician in several weeks. The follow up did not occur, however, as Joubert thought it was unnecessary in light of his disagreement with his physician's diagnosis.

Nine months later Joubert was involuntarily admitted again following threats made against his brother. Joubert was released after promising to adhere to his medication and follow up with a psychiatrist. More than a year later, Joubert was involuntarily admitted for a third time, on petition from his parents. They were concerned over his increasing agitation and refusal to take his medication. Joubert was released less than a month later, still belligerent with respect to adhering to his medication. In September of 2004, Joubert beat his parents to death in their home.[8] He was arrested and held involuntarily in a psychiatric facility pending psychiatric assessment for trial. In 2005, Joubert hanged himself in his cell.

Specific details of Joubert's history of mental illness are not known; however, his repeated involuntary admissions to mental health facilities, and repeated warnings from his doctors and parents (who were also doctors) should have made it clear to Joubert that it was critically important that he remain on his medication, especially in light of his paranoia and the threats made against his family. Joubert, through psychological testing, was shown to be intelligent in spite of his mental illness.[9] That is, he could understand what he was being told about his disorder, and the problem was that, in his non-medicated state, his paranoid delusions seemed to take over. What is unclear is whether or not Joubert was ever

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6 I will note here that the intent of this paper is not to bring further stigma upon the mentally disordered or to accuse them of being somehow naturally criminal or dangerous. Rather, this paper seeks to address what is often perceived as a failing in the justice system, one which arises sufficiently often to be worth addressing.

7 The Honorable Judge Ken Champagne, *Report by Provincial Judge on Inquest Respecting the Death of Paul Laurent Joubert*, (Winnipeg: 03 Aug 2007), accessed online at: <http://www.manitobacourts.mb.ca/pdf/joubert_inquest.pdf> [Champagne].

8 "Psychiatric testing for Manitoba man accused of killing parents" *CBC News* (17 September 2004) online: <http://www.cbc.ca/news/canada/story/2004/09/17/joubertcourt040917.html>.

9 Champagne, *supra* note 7 at paras 25, 37, 80.

really "treated" by his medication. If his medication never actually brought him out of his delusional state, then his non-adherence to medication could not be attributed to his own doing. On the other hand, if the medication helped him enough to make the delusions subside, then the question arises as to whether he ought to have been held responsible for failing to take his medication where such a failure contributed to the deaths of his parents.

It must be remembered that Joubert, despite his mental illness, functioned outside of the mental health system. He managed to hold down a job and care for himself, albeit with several lapses.[10] As such, it is more than arguable that Joubert, as an independent and reasonably self-sufficient member of the community, should be held responsible for his actions on a day-to-day basis, at least during his more stable periods. If he acted negligently in those stable periods (assuming they existed), then it is legitimate to inquire as to his criminal culpability. As Joubert committed suicide, it is moot in the practical sense to discuss what kind of culpability, if any, should be attributed to him for his failure to adhere to his medication schedule. Nevertheless, the scenario is one where the argument of this paper could apply.

As a point of contrast to Joubert there is the Vince Li case.[11] This case is arguably the most widely publicized and infamous Manitoba case in recent memory which involved the NCR defence; however, as there was no evidence that Li was aware of the danger that he might pose in a psychotic state or that he might be psychotic at all, he cannot properly be said to have exacerbated his own mental disorder. Unlike Joubert, Li was on no treatment regimen and so he cannot be said to have knowingly contributed in any way to his own deterioration by failing to adhere to one. As a matter of distinction, then, it must be clearly stated that Li or someone in similar circumstances would not be subject to the argument set out in this article. This distinction will be further discussed later.

In spite of this, many of the facts in the Li case serve as a useful hypothetical scenario. In the spring of 2009, both the Manitoba Court of Queen's Bench and the province's own "court of public opinion" considered and debated the NCR defence in the context of the Vince Li case. The case was widely publicized due to the extreme nature of the killing perpetrated by Li. Li and his victim were unknown to each other and shared adjacent seats on a Greyhound bus bound for Winnipeg. Li suffered from undiagnosed schizophrenia at the time, and in the midst of a delusion, he attacked the sleeping victim with a knife, killing and ultimately dismembering him and consuming part of the body. Legally speaking,

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10 *Ibid* at para 25.

11 Mike McIntyre, "Vincent Li found not criminally responsible for murder", *Winnipeg Free Press* (03 May 2009), online: <http://www.winnipegfreepress.com/breakingnews/Vincent-Li-found-not-criminally-responsible-40781652.html>.

it is uncontroversial that Li was suffering from a "disease of the mind"[12] that qualified him for the NCR defence. As heinous as the killing was, the NCR defence was properly applied.

The issue at hand, which might be termed as "the descent into an avoidable mentally disordered state", or a "failure to abate one's mental illness" is, of course, not at all unique to or especially prolific in Manitoba; nevertheless, the examples of Li and Joubert are useful to keep in mind when discussing the issue and possible legal consequences of avoidable mentally disordered state. What if Li had been diagnosed with schizophrenia and had been medicated? What if the medication worked, but for one reason or another he had discontinued it, his mental illness deteriorated, and then he got on the Greyhound bus? It is certainly not hard to imagine that events might have unfolded in this manner. Such issues also are raised when his release is discussed - even if Li is appropriately medicated, would he continue to take his medication and what should happen if he does not and more violence results? What if Joubert had made it to trial?

The substance of this paper is divided into six sections. The first discusses the set-up of the "recklessly-induced mental disorder" scenario in order to provide framework for an analysis. The second considers the philosophical motivation for punishing in such situations. The third is a brief survey of the history of the NCR defence to give context to the discussion. The fourth section is a detailed explanation of the NCR defence itself, which is necessary for a proper discussion of if and how a recklessly induced violent episode might lead to criminal culpability in the event that the disorder precipitates a serious crime. The fifth section proposes that recklessly exacerbating one's own mental disorder with the resulting injury or death of another should be considered criminal negligence. The sixth section of the paper very briefly discusses the possible forms of punishment which should accompany the proposed offence. The last section forms a brief conclusion.

It must be noted that the purpose of this paper is not to suggest a practical concrete form of sanction, but rather to argue that some sanction is warranted in the first place. The issue of precise legal punishment carries with it many intricate considerations which are not discussed in this paper - the proposed solutions presented in this paper are largely philosophical in nature, as opposed to practical logistical solutions.

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[12] "Disease of the mind" is defined in s 2 of the *Code*. This will be discussed at length in Section V of this paper.

II. WHAT IS AN "AVOIDABLE MENTALLY DISORDERED STATE"[13]

It is trite criminal law that a guilty mind must parallel a guilty action to create a criminal offence, and one's mental state is certainly considered when determining to what extent one should be held responsible for one's actions.[14] The question this paper will address is whether one who recklessly induces or exacerbates his own mental disorder by failing to take action to control it, if he is not disordered (as defined by the NCR defence) when he fails to act, can or should be held legally responsible for his actions where it subsequently leads to the commission of a serious crime.

This paper does not discuss the possible culpability of wilfully self-induced automatism. The courts have made it clear that purposeful or reckless use of drugs or alcohol creating a disturbed mental state does not constitute a "disease of the mind" as is requisite for the NCR defence, unless there is evidence of a pre-existing malfunctioning of the mental processes.[15] Importantly, this excludes several common scenarios of self-induced mental aberration from being considered in an NCR defence, such as extreme intoxication or paranoid delusion caused by recreational drug use. As it is clear that the NCR defence would not be available to an accused in those situations, it is moot to discuss whether there should be culpability with respect to their decision to become intoxicated in the first place.

The term "avoidable mentally disordered state" has a specific meaning here. It is, of course, incorrect to suggest that mental disorders can be willingly created or conjured from within oneself where one had no mental disorder before. Likewise, I do not mean to imply that having a mental disorder is something that can be avoided altogether. The phrase as I use it is meant to denote a situation in which a person who already has a mental disorder fails to take steps to abate it or actually acts to exacerbate it, thus the "avoidable" aspect of the term connotes acts or omissions involved in failing to abate the disordered symptoms of the condition where abatement of such symptoms was possible. Specifically, for the balance of this paper, when I speak of "avoidable mentally disordered state", I am referring to a situation involving all of the following conditions:

i) The person is afflicted with a mental disorder, the likes of which would constitute a "disease of the mind", as defined by the *Code*. The person would therefore potentially qualify for the NCR

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[13] From this point on in the paper, the male pronoun is used when referring to hypothetical offenders. The author intends no offense by this choice, but has chosen it for the sake of simplicity.

[14] Irving Thalberg, "Hart on Strict Liability and Excusing Conditions" (1971) 81:2 Ethics: An International Journal of Social, Political, and Legal Philosophy 150.

[15] *See DPP v Beard* [1920] AC 479 (UK HL); *R v Godfrey*, [1984] 3 WWR 193, 8 DLR (4th) 122 at para 31 (Man CA).

defence, as set out in the *Code*, if he was to commit a crime in that condition.

ii) The person afflicted is aware of his condition and has been successfully medicated such that adhering to the medication schedule as prescribed will put him into a "stable phase".[16] The stable phase renders him lucid and competent so as to negate the relevant effects of the disease of the mind and able to appreciate the nature and quality of his acts and know when they are wrong. He would, therefore, not have the NCR defence available to him if he were to commit a crime at this stage. This point is critical because if the person, despite proper adherence to medication, was still left with significant aspects of the "diseased mind" such that he never ceased to be NCR, then any exacerbation of his condition can still be attributed to the condition itself, and thus all of his actions would remain under the protection of the NCR defence.

iii) While the person is lucid and competent in his stable state, he fails to take his medication, which he knows, either from experience or from being told by a health care professional, is likely to result in a worsening of his mental condition. Specifically, he must know that he may lose the ability to tell right from wrong, that he may suffer from serious hallucinations, lose touch with reality, etc.

iv) Subsequently, as a result of discontinuing the medication, he returns to a disordered state such that he again has a disease of the mind and would again potentially qualify for the NCR defence.

v) The person commits a crime at this stage while he has a disease of the mind and cannot appreciate the nature or quality of the act nor does he know the act is wrong.

It would be useful at this stage to outline the standard treatment process which a mentally disordered person might face. This information pertains specifically to people with schizophrenia, as this paper deals primarily with cases concerning that mental disorder. Other mental disorders with similar symptomologies and treatment structures would fall under the proposal of this paper as well.

First, there is the "acute phase", wherein psychotic symptoms begin to manifest themselves. Patients may seek treatment at this point and emphasis is

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16 Pharmacotherapy, "Clinical Practice Guidelines for Treatment of Schizophrenia" (2005) 50:S1 Can J Psychiatry, 19S at 20S. Schizophrenia is broken down into three stages: acute, stabilizing, and stable. At the stable phase, the person is as stable as their medication can make them. Although the term applies to schizophrenia somewhat uniquely, for convenience, I will use the term "stable phase" to denote all analogous periods in other mental disorders, wherein the person is similarly and effectively medicated so as to leave them legally competent.

placed on evaluating them in terms of the level of danger which they pose.[17] The next stage is the stabilization phase, in which the person is medicated to reduce their positive psychotic symptoms. Adherence to medication is critical at this stage.[18] Finally, there is the stable phase, which is the focus of this paper. Relapse prevention is an important goal during this phase.[19]

Individual response to medication is highly variable, but the use of antipsychotic medications is an essential part of a treatment plan.[20] While undergoing treatment, patients are typically provided with information concerning the nature of their disorder, as well as the risks and benefits of treatment so that they may play an informed and participatory role in their treatment.[21] This means that the theoretical patient I refer to in this paper can reasonably be assumed to have been informed of the dangerous consequences which would accompany failing to adhere to his medication. If a patient had not been so informed and remained ignorant of the gravity of his mental illness and the importance of medication, he obviously should not be faulted if he fails to adhere to it.

While the patient still has the right to determine his own course of treatment or refuse it altogether,[22] this right is not absolute. In cases where the patient is not competent to make decisions the decision may be made for him. A determination of incompetence would involve consideration of whether he is mentally impaired to the extent that he does not understand the nature of his condition or the consequences of obtaining or not obtaining treatment.[23] For the purposes of this paper, I assume that the person in question is competent to make treatment choices.

Nevertheless, just because the patient has the right to choose to abstain from medication, does not mean that he should be able to do so with impunity. To the extent that exercising a right entails a foreseeable risk of harm to others, I think it is plain that a person ought to be held accountable for exercising that right.

As the issue of culpability in an avoidable mentally disordered state is analyzed, it may be helpful to keep in mind a specific scenario. Imagine a person who has schizophrenia, paranoid type, or a person with a condition similar to that of Li or Joubert. As with Joubert (but unlike Li), this person has been diagnosed by his doctor who has prescribed an anti-psychotic medication to be taken regularly. The medication is effective and alleviates most symptoms of the disorder, leaving him in a mentally stable phase. The medication produces some

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17 *Ibid* at 20S.

18 *Ibid.*

19 *Ibid* at 22S.

20 *Ibid* at 19S.

21 *Ibid.*

22 See *The Mental Health Act* , CCSM c M110 s 26.

23 *Ibid* at s 27(2).

deleterious side effects, including flattened affect (a strong dulling of emotions) and lethargy; but none of these seriously impact his ability to understand the consequences of his actions or understand the difference between right and wrong. As unpleasant as his treatment situation is, his judgment is not impaired. The doctor informs the person that his mental stability will only persist so long as he keeps taking his medication, and that failing to take the medication will result in a loss of stability, possibly leading to a dangerous psychotic episode. In spite of this warning, the patient decides one day to stop taking the medication because he has (understandably) grown tired of the side effects.[24] Subsequently, he does indeed lose control, has a psychotic breakdown during which his mental state is so disturbed that he does not understand or appreciate the nature or quality of his actions, and due to his delusions he kills his wife.

My question is: assuming that the NCR defence is available to this person with respect to his actions and mental states at the time he killed his wife, is there any criminal culpability that can or ought to attach to him with respect to his omitting to take his medication during his stable phase, which was ultimately the cause of the killing in the first place?

The situation above may sound like a contrived scenario, but events such as these do transpire. In *R v Weldon*,[25] the accused was diagnosed with schizophrenia and was constantly going on and off of his medication in spite of his doctor's repeated warnings that his mental state would deteriorate and that he would need hospitalization if he continued to do so. The accused ultimately stopped taking his medication and killed his wife in front of their child. On appeal, the Court held that the accused ought to have been afforded the NCR defence, and he was acquitted of the murder on those grounds. Should that have been the end of the inquiry?

Before proceeding to discuss the substantive matters behind my answer to this issue, I must acknowledge two important points before proceeding. Firstly, it must be noted that mental disorders are a variable phenomenon and not everyone

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[24] It is not uncommon for people with serious mental disorders to discontinue use of their medication. In a Korean study, some 71% of schizophrenics discontinued use of their medication for various reasons. See Seung-Ho Jung et al, "Factors Affecting Treatment Discontinuation and Treatment Outcome in Patients with Schizophrenia in Korea: 10-year Followup Study", Psychiatry Investigation 8:1, online: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3079182/>. As well, a Maryland study found 90.4% discontinued their medication at some point in the course of treatment. See C Daniel Mullins et al, "Risk of discontinuation of atypical antipsychotic agents in the treatment of schizophrenia", (2008) 98:1-3 Schizophrenia Research 8, online: <http://www.sciencedirect.com/science/article/pii/S0920996407001910>. I note that although this paper proposes sanction for reckless discontinuance of medication, it does so with a specific focus. Clearly it would not be tenable to punish discontinuation of the medication if it is the case that 90% of the relevant population does indeed discontinue it. Instead, the focus of this paper is directed at those who are prone to violence or who can otherwise foresee danger to others if they should discontinue their medication.

[25] [1995] 86 OAC 362, 29 WCB (2d) 52.

responds to medication the same way.[26] Grave psychological instability can persist even where a patient diligently follows his treatment regimen.[27] Obviously, in such cases where treatment is not effective there would be no reason to suggest that culpability of any kind be placed upon the patient because presumably he was never truly outside of the NCR threshold and therefore could not appreciate the consequences of failing to adhere to his medication. If, for instance, the person eventually discontinues his medication due to compulsion from his own hallucinations, then the medication may have never actually brought him outside of the NCR threshold; and he could attempt to avail himself of the defence, both with respect to the main offence and with respect to the discontinuation that lead to that main offence.

Secondly, I want to emphasize that the discussion of culpability for failing to abate one's own mental disorder is centered on the person's mental state and conduct while he was in the stable phase of his condition. Throughout history and to this day, serious stigmas have attached to mental illness, including notions that mentally ill people are violent threats to society or that they are morally and psychologically weak and somehow responsible for their condition.[28] The purpose of this paper is not to promote this misconception by suggesting an exception to the NCR defence which would allow the punishment of those mentally disordered individuals who neglect to take their medication; rather, the issue is whether culpability should flow based on what the person did while he was not suffering the debilitating effects of a disease of the mind, that is - when his judgment was not impaired during his lucid, legally competent, stable phase.

III. THE PHILOSOPHY BEHIND THE PROPOSAL

A. Motivation

One might think that the issue of recklessly induced or exacerbated mentally disordered state is academic and does not arise in practice. In fact, the issue does arise, but it is difficult to pursue case law on the matter because medication adherence is generally a factor considered in the disposition of the accused, and is irrelevant to the application of an NCR defence. As such, mention may be made of the offender's struggles with medication adherence in the context of discussions over whether he poses a danger to the public and whether or not to hold him in a psychiatric institution; but there is little reason for the court to discuss the issue in terms of criminal culpability outside administration of the NCR defence.

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[26] Pharmacotherapy, *supra* note 16 at 23S.

[27] *Ibid.*

[28] Mark Dombeck, *Essays and Blogs Concerning Mental and Emotional Health*, Online: MentalHelp.Net <http://www.mentalhelp.net/poc/view_doc.php?type=doc&id=686&cn=144>.

On the other hand, the issue is often debated in the public sphere and the perception that mentally ill offenders "get off easy" can run rampant. Some might worry that Li or other institutionalized individuals will one day be released and recede into unstable and dangerous habits. Whether the individuals end up doing so or not, it is important for both legally pragmatic reasons and those of public perception[29] that a process be in place to deal appropriately with avoidable mentally disordered states. If, for example, Li were to be released, having been declared stable and successfully medicated, but then went off of his medication and committed another violent offence, there should be a legal mechanism for responding to this development, in addition to simply re-committing him to the institution.

I think it is intuitive to seek punishment for someone with a mental illness when he commits a crime during his stable phase; that is, when he understood the consequences of his actions and that they were wrong. Surely we would all agree to the sanctioning of a person with a mental disorder who, while competent and lucid, set a dangerous trap which subsequently killed someone. At no point would this person be able to plead the NCR defence, as he was competent at all times. Would it make a difference to our intuitions if, after laying the trap and walking away, the person had a mental breakdown which would, from that point on, qualify him for the NCR defence? Presumably not, as the *actus reus* (setting the trap) accompanied an unblemished *mens rea* before the break down, leaving the offender as culpable as anyone else would have been at the time. That is to say, we would agree to punishing the conduct which existed before the activation of the NCR defence.

The next question is: would it make a difference to our intuitions on punishing the trap-setter if, instead of laying a trap while lucid and competent, the person decided to go off of his medication, also while lucid and competent? This person knew that he might be prone to violent episodes without his medication when he decided to do this, yet did so anyway. Two weeks later, in the midst of a psychotic episode, he killed someone. Clearly he should not be held to be culpable for the killing in itself, as the NCR defence would presumably apply, but what about his culpability for recklessly or intentionally setting into motion his own destabilization, which ultimately caused the killing? Assuming that

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[29] The law does not bow to public opinion but the perceived integrity of the legal system is sometimes considered. For example, when a *Charter* right of an accused has been breached and, as a result, evidence against the accused was obtained, the trier of fact must determine whether or not to exclude the evidence under s 24(2) of the *Charter*. In doing so, consideration must be given to, among other things, the public's confidence in the legal system and how it would be affected by excluding the evidence or not. *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 s 24 [*Charter*]. See *R v Grant* 2009 SCC 32, [2009] 2 SCR 353 for an explication of the test undertaken when determining whether or not to exclude evidence.

foreseeability of the consequences can be established in both cases, what morally relevant difference is there between laying a trap which kills someone two weeks later, and destabilizing himself so that he loses control and personally kills someone two weeks later? If we punish in one circumstance, should we not punish in the other, assuming that the foreseeability of harm is present in both situations?

It may be argued that the medicated person with a mental disorder is vulnerable, even in his stable phase, due to various side effects from medications or lingering psychological problems associated with his disorder. Due to this vulnerability, it might further be suggested that the person be held to a lower standard of care *vis-a-vis* his medication adherence. This argument should not be convincing. While the difficulties and vulnerabilities facing the person in adhering to his medication may have a place as a sentencing consideration,[30] there is a strong philosophical reason why being in this vulnerable state should not excuse the person from responsibility for the consequences of voluntarily failing to adhere to his medication schedule.

The criteria for use of the NCR defence set a certain threshold to meet before one can make use of the defence.[31] This will be discussed at length in Part V, but the essential elements of the NCR defence are that, at the time of the commission of the offence, the accused suffered from a disease of the mind such that he either did not appreciate the nature or quality of his actions or he did not know that what he was doing was wrong.

As per my assumptions above, a person in the stable phase of treatment would not meet this threshold. To excuse this person from any illegal or reckless conduct at this stage on the grounds that he is mentally disturbed would serve to dilute the NCR defence. Further, it will increase the public perception that having psychological difficulties falling far short of legal or medical "insanity" will nonetheless serve to exonerate the mentally disordered, and this perception would be damaging to the integrity of the legal system.

By analogy, we might be sympathetic for a person suffering from pyromania or kleptomania who, as a result of his mental disorder, is prone to setting fires or shoplifting; however, such mental disorders (falling short of the NCR threshold) should function at most as sentencing considerations and not as complete defences to arson and theft, as the *mens rea* for the offence (of setting the fire or stealing) is still present. Such an individual might instead receive a lenient sentence on the grounds that he was less culpable even though they "knew what [they were] doing ... and knew it was wrong"[32] or that the pre-dispositional nature of the mental disorder lessens the need for tough deterrent measures.[33] Likewise,

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30 *R v L (JHQ)* (1995) 61 BCAC 150 at paras 9-10.

31 *Criminal Code*, *supra* note 2 at s 16.

32 *R v Medwid* [1990] 89 Sask R 158 at para 6 (CA).

33 *Ibid* at para 8.

it makes sense to consider leniency of sentence, but *not* an absence of sentence or recognition of wrong-doing altogether, when it comes to non- adherence of mentally disordered individuals who do not meet the NCR threshold. In both cases, individuals are compelled but not controlled by their mental illness; thus they have the ability to form the *mens rea* of a crime. As long as they can do this, any other mental stressors or compulsions should, at most, function to reduce the culpability of the crime in question, but not deny that it took place at all. To hold otherwise would be to usurp the very meaning of "*mens rea*".

In addition, it would be doing a long term disservice to mentally ill people generally if we fail to hold them accountable for their conduct in their stable phase. As noted above, they face a great stigma[34] which would only be worsened if they were perceived to be so psychologically weak, even in their stable phase, that they need special consideration before being held accountable. It would be as if to say "I am stable, reliable, and I know the difference between right and wrong, but if I commit any crimes then it is not my fault and it can be blamed entirely on my disorder." This contradiction can only breed misconception and worsen the stigma which the mentally disordered person already faces.

Although taking this view may be seen as a failure to recognize the vulnerability of the medicated person, I see it as quite the contrary. It is recognition of the fact that people on medication for their mental illness are not habitually unreliable or weak-minded and should therefore be held roughly as accountable just as anyone else would be, while they are in their stable state.

While it is the state's prerogative to create criminal offences, a reasoned philosophical justification for a new law, in addition to its pragmatic functions, adds moral legitimacy to it; therefore, something should be said about the moral justification for creating an offence which would punish those who recklessly exacerbate their own mental disorder.

B. Punishment Theories: A Way to Justify Punishing

While there is incredible complexity and argument in the sphere of moral philosophy regarding punishment, two of the most significant schools of thought are the utilitarian theories and the retributivist theories. Both theories raise convincing points and may suggest certain plausible policies, but both also lead to absurd conclusions when taken to their logical extremes, perhaps suggesting that another theory should be considered.[35]

Utilitarian theories require and/or condone punishment only where it serves the social good.[36] This would include punishments which have deterrent or

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34 Dombeck, *supra* note 28.

35 Michael David, "Punishment Theory's Golden Half Century: A Survey of Developments from (about) 1957 to 2007" (2009) 13: 1 J Ethics 73.

36 *Ibid* at 78.

remedial effects by either preventing future crime or by making society a "safer place", for instance, by incarcerating offenders and keeping them off the streets in the short term while they are rehabilitated for (hopefully) the long term betterment of society. The problem with this theory is that it produces counterintuitive results in two possible scenarios. First, in cases where no social good would be served by punishment, the theory would disallow any punishment as it would, on balance, be more harmful than helpful. Imprisoning someone, thus lessening the amount of "good" (freedom, happiness, etc.) in the world, when it produces no "good" in return, would be wrong on this view. Problematically, this means that where there is no deterrent, remedial, or public safety effect, punishment cannot be justified and offenders get off "scot free". Some might argue that prison time is never a "good" because it hardens criminals at the worst and makes them difficult to reintegrate into society at best. If indeed this is true, then prison might very well be abolished altogether, on the utilitarian account, except perhaps in the second and even more counterintuitive set of circumstances, namely that the theory would condone punishing random innocent people if doing so would enhance the overall social good. That is, if it would be better to make an example out of an innocent person than to let the law appear to have been flouted or avoided by the true culprit who got away, then we should punish the innocent person.

Beyond the philosophical absurdities, there are practical reasons why a purely utilitarian justification for punishing NCR persons would not be tenable. There are many provisions in the *Code* relating to treating and rehabilitating NCR persons as a condition for their release back into society.[37] Therefore, since there are already safeguards in place to ensure public safety by denying the mentally ill's re-entry into society until they are better, there is arguably no social good to be obtained by further punishing the mentally ill person for their reckless actions which precipitated their mental instability. It is possible that there may be some deterrent effects to be had, insofar as non-adherence to medication would be recognized as potentially inculpatory, and this deterrence would function as a social good justifying punishment on the utilitarian account; however, I think it is clear that the primary motivation in punishing reckless omissions of medication adherence is in reality largely based on the desire to punish a perceived moral wrong – that is, retributive justice and social denunciation.

Retributivist theories of punishment presuppose a unified moral theory (which may vary by society) and condones punishment where the moral theory is violated.[38] Such theories may be as fundamental and simple as the imperative of adhering to the state-made laws of the land or may involve higher-order ethical

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[37] *Criminal Code*, *supra* note 2 at s 672.54.

[38] Thom Brooks, "Kantian Punishment and Retributivism: A Reply to Clark" (2005) 18:2 Ratio 237 at 241.

principles, such as the imperative of doing no harm to others.[39] The key to this theory is that justice is seen to be done when the wrong-doer is punished for flouting the moral theory, whatever it may be. There is no concern over deterrence or remedial effect. Unfortunately, this is precisely the problem for the retributivist theory, as it would seem to condone pointless punishments where no good is served (no deterrence or remedial effect) merely because a law was broken or because someone else was wronged by the actions of the offender. This has the potential of leading to harsh consequences in some instances.

One particularly salient retributivist theory might be dubbed the "Removal of Unfair Advantage Theory."[40] On this theory, to achieve justice we must balance burden with advantage. Punishment is a means with which to achieve justice by balancing out ill-gotten advantages with burden - the burden being the punishment itself. The law imposes burdens on us that we engage or refrain from engaging in certain conduct, and failing to undertake these burdens constitutes an ill-gotten advantage, the likes of which needs to be "balanced" with the burden of punishment.[41] There is room for the application of this theory to reckless deviation from a mentally ill person's medication schedule. To the extent that the lack of self-restraint (or in the case of mental illness, a lack of taking medication to restrain one's self) is an advantage, this theory would seem to recommend punishment as a balance. But does this theory go too far? On the face of it, the theory would seem to allow a person who discontinues his medication to be punished, even if he does not hurt anyone, simply because he took an advantage in a reckless manner. To punish always in this case would be to go too far.

In any event, if, as I will propose, criminal negligence is the best way to frame the situation of recklessly exacerbated mental disorder, then the negligence would have to have caused either serious harm or death. One cannot be charged with "criminal negligence causing nothing", if he recklessly went off of his medication and nothing happened. It is the wilful risk-taking combined with the outcome (injury or death) which merits the punishment, just as with other charges of criminal negligence.[42]

Given the problems present in the utilitarian and retributivist theories, it seems desirable to base a justification for punishment of those who recklessly exacerbate or fail to abate their own mental disorder upon some sort of combined theory. Michael David summarized the relatively more recent "fairness theory" of punishment, noting that

> ...legal punishment (and close analogues) are justified (that is, morally permissible, positively good, or both) insofar as it supports the (relatively just) distribution of benefits

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39 David, *supra* note 35 at 79.

40 RA Duff, "Penal Communications: Recent Work in the Philosophy of Punishment " (1996) 20 Crime & Just 1 at 26.

41 *Ibid.*

42 See discussion in Section V below.

> and burdens that a relatively just legal system (or similar practice) creates. A relatively just legal system is a cooperative practice from which each benefits if others generally do their part and in which doing one's part is sometimes burdensome.... Punishment, when justified, is justified as corrective justice, that is, as part of maintaining a just legal order. Maintaining a just legal order is good in itself and – all else equal – morally permissible.[43]

This theory, though perhaps imperfect for various reasons not relevant to this discussion,[44] offers an adequate moral justification of the punishment of recklessly exacerbated mental disorder, and appears to consider aspects of both utilitarian and retributivist theories. At first blush, one might think it unfair to hold people with mental disorders accountable for failing to take their medications because even while medicated many will still be encumbered and disturbed by side effects or lingering aspects of the disorder. The fairness theory of punishment adequately answers this worry. It recognizes the burden which those with mental disorders must face, including the stigma and the side effects from medication which they must take; however, it simultaneously recognizes the burden which society must shoulder. Although perhaps not the best word, this social "burden" is constituted by the safety concerns which the public would face if those with serious mental instabilities were not medicated. While the balancing of burdens here sounds highly similar to the "Removal of Unfair Advantage" retributivist theory, this theory may be more desirable insofar as it justifies but does not demand punishment in all cases where a mentally ill person goes off of his medication. It is therefore open to argue that the burden imposed upon the person with paranoid schizophrenia to diligently take his medication is a legitimate one which is justified by the possible dangers he would present to society if he went without medication. As noted, this theory stops short of demanding sanction in all cases, especially where no actual harm is done.

The fairness theory of punishment does an adequate job justifying the punishment of those who recklessly exacerbate their own mental illness, but regardless, one can readily imagine a justification based on a combination of retributivist and utilitarian reasoning, including both deterrence and the punishment of immoral conduct. I will proceed from here on the assumption that the introduction of such a punishment is philosophically justifiable.

In addition to moral philosophical justifications of punishment, at a more concrete and legalistic level, the *Code* itself offers assistance in justifying punishment for recklessly discontinuing an anti-psychotic regimen where it causes death or serious injury. The *Code* sets out the broad purposes of punishing offenders,[45] which include denunciation of unlawful conduct, deterrence, separation from society, rehabilitation, reparations, and the promotion of a sense of responsibility in the offender. While all of those goals are arguably served at

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[43] *Supra* note 35 at 94

[44] *Ibid* at 95-96.

[45] *Criminal Code*, *supra* note 2 at s 718.

least to some extent by punishing reckless exacerbation of mental disorder, it seems clear that the aspects of denunciation and the acknowledgment of responsibility would be the substantial motivation behind the punishment.

Between the possible justification found in utilitarian, retributivist, and fairness theories of punishment, as well as the provisions found in the *Code*, it seems clear that punishing reckless exacerbation of mental disorder can, in principle, be justified.

IV. A HISTORY OF THE NCR DEFENCE IN SEVERAL OF ITS ITERATIONS

A glimpse at the common law history of treatment of mentally disordered people shows a pattern of disdain and comparison to children and animals. Despite the base nature of such comparisons, it is clear that in some cases it would be as senseless to hold a mentally disordered person morally blameworthy for their crime as it would be to hold an animal or child blameworthy of the same offence. From its early conceptions as a disqualification of ability to transact or control one's self, to its more modern function of denying *mens rea*, the law on crime and mental incapacity has had a colourful history. It is clear today that the wording of section 16 of the *Code* establishes the NCR defence as an "excuse-type" defence which denies the requisite *mens rea* of the offence, thus precluding a finding of guilt; however, a brief historical analysis of what we now know as the NCR defence is warranted in order to give context to the proposed sanctioning of conduct which both precedes and precipitates the NCR defence itself.

A. Medieval Times

Hints of a requirement of a mental element in a criminal offence have persisted though out ancient legal history;[46] however, one of the earliest and most significant movements in English jurisprudence toward a more uniform recognition of the requirement of both a *mens rea* and an *actus reus* to constitute a crime came in the 13th century. Henry de Bracton, an eminent jurist of the time,

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[46] For instance, in ancient Rome, the law held that the insane were legally incompetent and therefore were designated as wards of their guardians or *curators*. See Adolf Berger, *Encyclopedic Dictionary of Roman Law* (Philadelphia: American Philosophical Society, 1953) at 420. In ancient Hebrew law, deaf-mutes, minors, slaves, married women, and "idiots" (the mentally disordered) were considered "awkward" to deal with, and therefore if they were to injure others then they were to be exempt from the punishment which would normally follow such a crime. Babylonian Talmud, *Bava Kama*, 87a. This has consistently been interpreted to mean that someone who is *non compos mentis* (not of sound mind) is not legally competent – see Rabbi Simcha Roth, "Mishnah study in the religious climate of Masorti (Conservative) Judaism" Beit Midrash Virtual of the Rabbinical Assembly in Israel (4 November 2010), online: <http://www.bmv.org.il/shiurim/bk/bk080.html>.

was most responsible for this as he held that "[w]e must consider with what mind ... a thing is done ... in order that it may be determined accordingly what action should follow and what punishment. ... [Y]our state of mind gives meaning to your act, and a crime is not committed unless an intent to injure ... intervene[s]."[47] De Bracton did not originate the idea of *mens rea*, however much his act of composing and amalgamating decades of disparate common law on the subject and placing an emphasis on the requirement for *mens rea* did serve to solidify it.[48] As the presence of *mens rea* became a necessity for criminal offences, the mentally disordered were necessarily disqualified from committing such offences in virtue of their lack of an operating mind, and thus the incapacity of the mentally disordered was codified as part of the common law.

B. The 17th Century and Coke's *Institutes*

In 17th century England, there were several distinct classes of legal incapacity which would render a mentally disordered person immune from prosecution for his acts. Edward Coke had penned the *Institutes of the Laws of England*,[49] a series of legally instructive books based on actual cases. Simply dubbed "The Reports", it was subsequently regarded as a corner stone in the development of the modern common law, and in that respect, has been regarded as "perhaps the single most influential series of named reports."[50] Coke surveyed case law and synthesized four classes of *non compos mentis*, the state of being not of sound mind, which may be paraphrased thusly:[51]

i) A person who has been perpetually mentally infirm from birth.

ii) A person who, due to illness, grief, or accident, loses memory and understanding.

iii) A person who has periods of understanding and competence and periods without understanding and competence, where such person is only *non compos mentis* during the periods where he loses understanding and competence.

iv) A person who by his own act deprives himself of his memory and understanding, similarly to the situation of intoxicating one's self. This kind of *non compos mentis* shall not give the person a privilege.

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47 Henry de Bracton, *De Legibus Consuetudinibus Angliae*, reprinted in FB Sayre, "Mens Rea" (1932) 45 Harv L Rev 974 at 985.

48 Jacques M Quen, "Anglo-American Concepts of Criminal Responsibility: A Brief History" in SJ Hucker et al, eds, *Mental Disorder and Criminal Responsibility* (Toronto: Butterworth & Co (Canada) Ltd, 1981) at 1.

49 A vast number of versions of Coke exist, far too many to cite here. Quen used Edward Coke, *Institutes of the Laws of England*, vol 3 (Philadelphia: Robert H Small, 1853).

50 J H Baker, *An Introduction to English Legal History*, 4th ed (London: Butterworths, 2002), at 183.

51 Quen, *supra* note 48 at 2.

The last two classes are of particular interest for the purposes of this paper. The third class appears to refer to, among other things, people with treatable mental disorders or otherwise those with intermittent positive psychotic symptoms. The fourth class refers to self-induced intoxication but could arguably be interpreted as failure to adhere to one's medication schedule for treating their mental disorder. Though the passage emphasizes "by his own act", there is no principled reason to exclude omissions. The combined effect of the third and fourth classes seems to suggest, quite intuitively, that if a person commits an act (or an omission) while he is of sound mind which has the effect of depriving him of said soundness of mind, then the act (or omission) leading to the deprivation "shall not be given privilege". The precise meaning of "privilege" is not critical, as the passage suggests, in a general sense, that this particular brand of "unsoundness of mind", that being self-induced, would not be a legitimate defence for the accused. Despite the fact that the use of medication and pharmacotherapy was likely not anticipated by Coke in his writings, it is a coherent interpretation of the classes of *non compos mentis* that they would not offer protection to the omission of taking one's medication.

In 1724, *Arnold's Case*[52] set a very high bar for reliance on the insanity defence, seemingly requiring a complete lack of reasoning capacity. Arnold was under the delusional belief that the person he had shot at, Lord Onslow, was responsible for the problems of the country and that he caused monsters to appear in his bedroom. The Court held that in order to make use of the insanity defence, the accused must "[be] totally deprived of his understanding and memory, and doth not know what he is doing no more than an infant, than a brute, or wild beast. Such a one is never the object of punishment."[53]

C. England in the 19th Century

Up until this point in history, the standards of insanity were high if one sought to rely on the insanity defence, as *Arnold's Case* decreed that to be acquitted one's insanity must be fairly all-encompassing, and transient delusions would seem not to suffice.

A substantial change to the understanding of the insanity defence came in 1800, after the trial of James Hadfield[54], which marked the first significant expansion of the defence. Hadfield had suffered brain damage in the Franco-British wars of the 1790s, which left him delusional. Hadfield sought to commit suicide because he thought it would save the world, but recognizing suicide as a sin, he tried to engineer his death as a penalty for attempting regicide. His attempt on the King's life failed and at trial his lawyer, Thomas Erskine, successfully

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52 *Arnold's Case* (1724), 16 State Tr 695.

53 *Ibid* at p 765, as cited in Quen, *supra* note 48 at 3.

54 *R v Hadfield* (1800), 27 State Tr 1281.

argued for a new construal of "total insanity."[55] Erskine noted that true total insanity, where one does not understand who he is, where he is, or what he is doing, does not exist; rather, insanity may be "delusion where there is no frenzy or raving madness...".[56] Thus, the ground work was laid for the insanity defence to be considered in cases where the accused is merely deluded, notwithstanding his capability of some level of reasoning and forethought. This change represents a marked departure from the traditional characterization of the insane as "idiots"[57] or "wild beasts",[58] insofar as otherwise relatively intelligent people could be considered insane in the right circumstances.

D. The M'Naghten Rules

The M'Naghten rules originated from *M'Naghten's Case*,[59] and continue to form a large basis for the modern conception of the NCR defence. M'Naghten had fatally shot the English Prime Minister's private secretary, believing him to be the Prime Minister himself. His motivation in doing so was his delusional belief that the government was persecuting him. M'Naghten was clearly able to make out his insanity plea but his acquittal sparked public outcry which resulted in a formal judicial "clarification" of the law on the insanity defence.[60] Thus, the M'Naghten rule was declared as follows, that, in order to acquit a person on grounds of insanity,"[i]t must be clearly proven 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 what he was doing was wrong."[61]

While this characterization of the defence was simple, it presented a severe problem which persisted until rather recently in Canadian jurisprudence[62], which I will discuss below. The benefit of the M'Naghten rules is that they set out a uniform guide by which to solicit expert evidence in determining the sanity of the accused at the time of the alleged offence. It was no longer a question of the accused's general mental competence, sanity, or predilections. The expert would simply be asked whether or not he thought the accused was deprived of his understanding of right and wrong or his understanding of the nature and consequences of his acts, with respect to the offence.[63] In England, the following

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55 Quen, *supra* note 48.

56 *Ibid.*

57 Berger, *supra* note 46.

58 *Arnold's Case*, *supra* note 52.

59 *Daniel M'Naghten's case* (1843), 10 Cl & F 200 at 210, 8 ER 718.

60 Quen, *supra* note 48.

61 *Supra* note 59 at 722 [cited to ER].

62 *R v Chaulk* [1990] 3 SCR 1303.

63 FA Whitlock, *Criminal Responsibility and Mental Illness*, (Toronto: Butterworths & Co, 1963) at 9.

century saw great reliance on the M'Naghten rules, but perhaps only in a technical sense. Frequently, juries seemed to disregard their instructions as to the application of the M'Naghten rules and rendered decisions based on their lay perceptions of the accused's sanity.[64] So, while the defence of insanity was meant to be a question strictly concerning the mental state of the accused when he committed the crime, it often happened that this technical requirement would be overridden by considerations of whether the accused was insane in general.

In Canada, the *Code* largely adopted the language of the M'Naghten rules,[65] but in doing so opened the door to another set of problems.

V. THE CURRENT DEFENCE IN CANADA – THE NCR DEFENCE

No longer the "insanity defence", in Canada, one may be acquitted of a crime on the basis that he was "not criminally responsible". The *Code* sets out the following provisions for the NCR defence:

> 16. (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) "mental disorder" means a disease of the mind.[66]

There are two main requirements which must be met in order to successfully raise the NCR defence. First, the accused must have been suffering from a disease of the mind at the time he committed the crime. This requirement is simply to exclude those prone to bursts of rage, transient intoxication, and those of lesser intelligence.[67] Regarding the definition of disease of the mind in more recent Canadian jurisprudence, Dickson J (as he then was) held in *R v Cooper* 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."[68] Similar sentiment was expressed in *R v Rabey*[69] by the minority (who dissented for independent reasons), to the effect that a disease of the mind may be "curable or incurable, temporary or not, recurring or non-recurring...".[70] It is significant that the term "disease of the mind", as it is employed in the context of the NCR defence, is a legal term and

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64 *Ibid.*

65 Mr. Justice GA Martin, "Mental Disorder and Criminal Responsibility in Canadian Law" in SJ Hucker et al, eds, *Mental Disorder and Criminal Responsibility* (Toronto: Butterworth & Co (Canada) Ltd, 1981) at 15.

66 *Supra* note 2, ss 2 and 16.

67 Martin, *supra* note 65 at 15.

68 [1980] 1 SCR 1149 at para 51.

69 [1980] 2 SCR 513.

70 *Ibid* at para 45.

not a medical one. The question as to whether or not a person suffers from a disease of the mind is a question of mixed fact and law. Expert medical evidence of the mental state of the accused is relevant and is considered by the court; but it is the trier of fact, and not a doctor, who will ultimately determine whether the person in question has a disease of the mind.[71]

It is thus clear that serious mental disorders such as those involving psychoses (such as schizophrenia),[72] or other disorders which cause delusions,[73] constitute diseases of the mind; which would satisfy the first requirement for application of the NCR defence. Of course, it is not a requirement that one suffer from some sort of psychosis before he can be deemed to possess a disease of the mind.

The second requirement for making use of the NCR defence is that the accused must fit under one of two "branches" set out by s 16(1) of the *Code*. The accused must either have been unable to appreciate the nature and quality of his acts or omissions or he must have been unable to understand whether or not they were right or wrong. The incapability requirement for both branches is high. A person is incapable only when there is a complete loss of capacity to appreciate the nature and quality of the act, or know it is wrong; it is not merely an inability to calmly consider the act.[74]

A. The First Branch: Appreciating the Nature and Quality

As set out in *Abbey*[75], if the accused is under a delusion or is otherwise unable to truly understand the consequences of his actions, the *mens rea* of his crime is negated. This is because the accused, despite "knowing" what the consequences of his acts would be, did not "appreciate" them. Appreciation requires a full understanding and ability to analyze information, whereas to know something is to merely have a base level awareness of it.[76] For instance, I might "know" that I have a vial of poison, yet innocently give it to a thirsty friend to drink without appreciating that quenching his thirst in such a way will also kill him. Therefore, even if an accused can accurately recite the basic cause and effect circumstances of his crime (understanding that stabbing someone can kill them), and even understand that he might face penal consequences, he may still fit under this branch if he was under a fundamental mistaken apprehension about the situation. For instance, if the accused thought that he was the embodiment of God and must kill Satan, who is really his innocent neighbour, then he would fall

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71 *Ibid* at para 9. See also *R v Stone*, [1999] 2 SCR 290, 134 CCC (3d) 353 (SCC) at para 176.

72 See *R v Weldon* (1995), 86 OAC 362 (Ont CA); leave to appeal refused (1996), 94 OAC 400 (SCC).

73 See *R v Abbey*, [1982] 2 SCR 24 [*Abbey*].

74 *R v Schwartz*, [1977] 1 SCR 673 at para 31 [*Schwartz*].

75 *Abbey*, *supra* note 73 at para 14.

76 *R v Barnier*, [1980] 1 SCR 1124 at paras 15-19.

under this branch of the test.[77] In summary, this branch of inquiry is only concerned with whether the accused really understood what he was doing, and not whether or not he thought it was wrong.

B. The Second Branch: Knowing it was Wrong

At this stage of inquiry, the focus shifts to whether the accused knew that what he was doing was wrong, as it has been established that he indeed appreciated the nature and consequences of his actions. The problem left over from *M'Naghten's Case* was with the meaning of "wrong", as it was then put in the phrase "...he did not know what he was doing was wrong".[78] As similar words comprise part of s 16(1) of the *Code*, it became necessary for the courts to determine what exactly "know" meant. The Court did just this in the *Chaulk*[79] case. In *Chaulk*, two youths bludgeoned to death the occupant of a home they had broken into. Both youths suffered from a paranoid psychosis which made them believe that they could kill with impunity, despite their parallel knowledge that killing was against the law in Canada. That is, the accused knew at the time of the killing that what they were doing was legally wrong, but their psychoses made them believe that they were not morally wrong in killing. Up until this point, the definition of "wrong" was restricted to "legally wrong"[80].

In *Schwartz*, the majority held that knowledge of the legal wrongness of an act would necessarily imply knowledge of moral wrongness, as it was taken for granted that it is morally wrong to break the law. This view was motivated by a "floodgate" worry that allowing "wrong" to mean "morally wrong" in itself would allow morally vacuous offenders to claim that their misdeeds were not wrong according to them, thus qualifying them for the NCR defence. Dickson J (as he then was) for the minority held that "wrong" should include both legal wrongness and moral wrongness. This was because, as occurred subsequently in *Chaulk*, it is possible for one to both know that something is legally wrong, and yet feel morally justified (or even obligated) to do it anyway. He also foreclosed on the possibility of a flood of subjective morality justifications, as he noted that "'[m]oral wrong' is not to be judged by the personal standards of the offender but by his awareness that society regards the act as wrong".[81]

The Court in *Chaulk* adopted the position of Dickson J's dissent in *Schwartz*, and the modern meaning of "know" with respect to "wrongness" in the NCR defence now includes both legal wrongness and moral wrongness. [82]

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77 This was the case in *R v Landry* [1991] 1 SCR 99.

78 *Supra* note 59.

79 *R v Chaulk*, *supra* note 63.

80 *Schwartz*, *supra* note 74.

81 *Ibid* at para 5.

82 *Supra* note 62 at para 101.

Despite the complex and evolving jurisprudence on the matter, the second branch of the NCR defence can be aptly summarized as "...available if an accused proves on the balance of probabilities that he suffer[ed] from a disease of the mind that render[ed] him incapable of knowing that his act was legally or morally wrong."[83]

VI. Reckless Exacerbation of Mental Disorder Causing Harm or Death is Criminal Negligence

Having reviewed this history and current interpretation of the NCR defence, and considering the scenario posed at the beginning of this paper involving someone who recklessly discontinues their anti-psychotic medication, two main points emerge. First, just as in the *Weldon* case,[84] it seems to be of little import to the NCR defence itself whether or not the mentally disturbed person was reckless with regard to taking his medication. While adherence to medication may be a factor influencing the release of a mentally disordered patient already held involuntarily after pleading the NCR defence,[85] there is no statutory nor common law provision which allows it to be considered by a court assessing the validity of the NCR defence. The second point emerging from the history of insanity defences as well as the surveyed moral philosophy is that people should be held accountable for their actions made while they were of sound mind or otherwise capable of forming a *mens rea*.

I believe these two points can be reconciled, and this reconciliation forms the proposal of this paper. While it is surely not the case that neglecting to take one's medications should carry with it the same criminal culpability and punishment as a murder, the fact that the former lead to the latter and the accused was able to foresee this suggests that there should be some culpability and punishment attached to the former act or omission.

Where the person who is medicated is of sound mind (outside the NCR threshold) at the time he recklessly discontinues his medication regimen and as a result has a psychological episode in which he hurts or kills someone, we should frame the omission to take the medication as criminal negligence causing death or bodily harm. As it is only the omission itself which is criminalized, the accused may still rely on the NCR defence in respect of the injury or death which he caused in his disordered state. Of course, the punishment would have to fit the crime and should involve consideration of the accused's precarious (albeit not NCR) mental state at the time the reckless disengagement from treatment

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83 *R v Worth* (1995), 40 CR (4th) 123 (Ont CA) at para 10.

84 *Supra* note 25.

85 *Criminal Code*, *supra* note 2, s 672.81(1.2).

occurred. The following is a detailed analysis of my proposal, addressing the crime as well as the appropriate punishment.

The *Code* defines criminal negligence as follows:

> 219. (1) Every one is criminally negligent who
> (*a*) in doing anything, or
> (*b*) in omitting to do anything that it is his duty to do,
> shows wanton or reckless disregard for the lives or safety of other persons.
> **Definition of "duty":**
> (2) For the purposes of this section, "duty" means a duty imposed by law. [86]

This definition of criminal negligence is supplemented by the common law and yields several requirements which must be met in order to prove a case of criminal negligence. Of course, one is not charged with "criminal negligence", but rather criminal negligence causing bodily harm or death. The following sections outline the essential elements of the offences and demonstrate how the reckless failure to abate one's mental disorder can satisfy those requirements.

A. Parts 1(a) and 1(b) Suggest the Offense May be Constituted by Either an Action or Inaction.

Clearly, the wording of the provision in the *Code* leaves open the possibility of failing to take one's medication as constituting the *actus reus* of criminal negligence, as an inaction. This requirement is therefore met, presumably without much contention.

B. The *Mens Rea* Requirement of Criminal Negligence is Objective

As the *Code* requires a "wanton or reckless disregard for the lives or safety of others" in order to establish criminal negligence, it is necessary to determine what standard of conduct and *mens rea* is anticipated by these words in order to see if neglecting to take anti-psychotic pills would fall under the offence.

As there is no mental state involved in criminal negligence *per se*, the standard of conduct is objective. While the *mens rea* of criminal negligence has always been a contested subject in Canadian jurisprudence, the Supreme Court of Canada began to set the standard in *R v Tutton*,[87] however, the Court was divided on the question of whether criminal negligence is a purely objective offence, or a mixed subjective/objective offence. Three justices held the standard to be purely objective, while three concluded that there is a subjective component to consider, holding that "...'reckless disregard for the lives or safety of other persons'...read in the context of Canadian criminal law jurisprudence, requires the Crown to prove

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86 *Ibid* s 219.

87 (1989), 48 CCC (3d) 129.

advertence or awareness of the risk that the prohibited consequences will come to pass."[88] The standard has been expanded upon in subsequent cases. In *R v Gingrich*,[89] the Ontario Court of Appeal held that

> The crime of criminal negligence is negligence. There is no need to import the concept of a subjective intent in order to obtain a conviction. The crime is the well-recognized tort of civil negligence; the sins of omission and commission that cause injury to one's neighbour, elevated to a crime by their magnitude of wanton and reckless disregard for the lives and safety of others.[90]

An interesting analogy emerges from this case. Gingrich was charged and convicted of criminal negligence involving deaths caused by a motor vehicle accident. Gingrich was a truck driver and was scheduled to head home after a delivery out of province. He was aware of the fact that his tractor-trailer's brakes were not working before he set out, and despite the ability for him to wait and obtain a replacement part, and his knowledge of what might happen if he was to lose control of his vehicle without his brakes, he set out on his return voyage. At some point he lost control of the truck, the brakes did not work, and two people died in the ensuing crash. If one can be convicted of criminal negligence for not ensuring that one's brakes were working while fully aware of the risk that it entailed, perhaps one should also be so guilty of failing to ensure that one's own "mental brakes" are in working order, where one has the ability to do so? It is not so specious an analogy to think of anti-psychotic medicine as "brakes" which help control an otherwise potentially unstable and dangerous person, in those cases where the person has been informed that his instability is of a dangerous nature.

The Supreme Court of Canada more conclusively set the standard for criminal negligence in *R v Creighton*.[91] The crown must prove that a reasonable person in the context of the offence would have foreseen the risk of death (or injury) created by his conduct.[92] The matter of what constitutes a "reasonable person" is a significant concern here. What standard shall the person who recklessly discontinues his medication be judged by? The "reasonable ordinary person with no underlying mental disorder", or the "reasonable person with a serious but successfully medicated mental disorder who suffers some side effects of the medication"? One could argue that the standard would be much lower in the latter instance because it would take into account the frailties of the accused suffering from his disorder. In actuality, the latter standard is not lower than the former, as will be explained, so it really makes no difference which characterization of a reasonable person is used, be it the "average mentally healthy person" or the "average mentally disordered but medicated person".

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88 *Ibid* at para 12.

89 (1991), 65 CCC (3d) 188 (Ont CA).

90 *Ibid* at para 39.

91 [1993] 3 SCR 3 [*Creighton*].

92 *Ibid* at para 37.

McLachlin J (as she then was) for four of nine justices in *Creighton* held that "considerations of principle and policy dictate the maintenance of a single, uniform legal standard of care...subject to one exception: incapacity to appreciate the nature of the risk which the activity in question entails."[93]

As I have posited earlier, assuming that the person with a mental disorder is lucid while medicated and below the NCR threshold, then they necessarily have *legal capacity* to appreciate the risks of non-medication adherence; therefore they are subject to the same objective standard as anyone else would be. Failing to take anti-psychotic medication which might cause a violent break down would clearly run counter to the conduct of the reasonable person.

On the other hand, Lamer, CJ (as he then was), for another four of nine justices in the same case, held that "the reasonable person will be invested with any enhanced foresight the accused may have enjoyed by virtue of his or her membership in a group with special experience or knowledge related to the conduct giving rise to the offence."[94]

Although this technical distinction from McLachlin J's judgment is generally significant, I do not think it is of critical import to the instance of medication adherence. Where one has a mental disorder and has been both medicated and informed of the consequences of failing to adhere to the medication, then such a person indeed possesses such special foresight and knowledge, raising his standard of care. Thus, even on the account of a reasonable person set out by Lamer CJ, the standard of care is still fairly high, albeit perhaps not quite as high as the pure objective standard advocated by McLachlin J. Lamer CJ made special reference to "frailties" while enunciating the "checklist" for criminal negligence. Such frailties would reasonably include those caused or instanced by mental disorders; however, such frailties are not necessarily exculpatory, as:

> A key element of the objective test is that of the control an accused could have exercised over the frailty which rendered him or her incapable of acting as the reasonable person would in the same circumstances. The notion of control is related to that of moral responsibility; if one is able to act prudently and not endanger the life of others, one will be held liable for failing to do so. One must be morally - and criminally - responsible to act according to his or her capacities not to inflict harm, even unintentional harm.[95]

It was further held that the frailties or traits which might serve as contextual considerations must be things which "the accused could not control or otherwise manage in the circumstances."[96] From this, it is clear that one who fails to take his anti-psychotic medication has failed to act prudentially in a manner which would have otherwise mitigated his own frailties. While it is true that the side effects from the medication may have induced yet more frailties, they could not be said

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93 Ibid at paras 119-120.

94 *Ibid* at para 37.

95 *Ibid* at para 39.

96 *Ibid* at para 44.

to be overpowering, assuming that they did not push the person into the NCR threshold at that time.

Given the relatively high standards of care and conduct set out by both judgments in *Creighton* pertaining to culpable negligence, I would entertain either standard in the analysis as to whether or not the person who discontinued his anti-psychotic medication was criminally negligent. Whether one subscribes to Lamer CJ's "modified objective" standard or McLachlin J's "pure objective" standard, both would equally condemn the reckless discontinuation of the medication. Non-adherence to anti-psychotic medication would clearly violate the pure objective standard of conduct and would also, in the right circumstances, violate the modified objective standard. This is because the reasonable person in that case would be vested with the special knowledge of his disorder and medication, which would serve to counter any frailties which might have otherwise served to lower his standard of care.

Having disposed of the *mens rea* component of criminal negligence, one must define the *actus reus* component. In *Creighton*, the Court held that in order to constitute culpable negligence the act itself must have represented a "marked departure from the standards of the reasonable person in all the circumstances of the case."[97] Recalling the analogy I drew involving the *Gingrich* case and failing to ensure that one's brakes are in working order, I think it is plain to see that if, in that case, driving with faulty brakes represents a marked departure from the conduct of the reasonable person, then so too should operating without one's anti-psychotic medication. Quite simply, where the risk is great and includes a possibility of significant harm, and where the person knows this and has been given a method by which to greatly reduce or eliminate the chance of such an eventuality occurring, then indeed it is a marked departure from the standard of the reasonable person to disregard such preventative measures. This holds true even where the reasonable person is a "reasonable medicated person suffering from schizophrenia", for the same reasons given in the discussion on *mens rea*.

In summary, there is good reason to believe that recklessly discontinuing anti-psychotic medication would satisfy the *mens rea* and *actus reus* requirements of the offence of criminal negligence. As in all negligence, foreseeability is the pivotal matter, and regardless of which technical standard of care the accused is judged by, it seems clear that where the possibility of harm to others is foreseen and disregarded, then criminal negligence may have occurred.

It may be argued that those with mental disorders who are successfully medicated (and who otherwise might be prone to violence or psychotic episodes) would not be likely to foresee themselves, now stable, ever becoming violent, and so the foreseeability of violent consequences through the discontinuation of medication is lacking. Indeed, the evidence is that most people who are psychotic

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97 *Ibid* at para 144. See also para 37.

are not violent,[98] but this does not mean that it would be unreasonable to suggest that, while stable, the person with the mental disorder would not foresee harm arising if he should discontinue treatment. As noted above, whether the standard of foresight in criminal negligence is to be purely objective or to have a subjective component as well, I think that in many cases this foresight will exist. The individual need not foresee in great detail the extreme and unlikely scenarios which might arise if he should discontinue his medication, nor must the risk of harm be especially likely to constitute the requisite foresight; rather, he need only understand, as evidenced to him either by his doctor's warnings or by his own experience, that he may lose touch with reality and could possibly become violent if he should stop taking his medication.

I must reiterate that in those cases where the person suffering from the mental disorder is not aware of the danger which he may pose to himself or others when he is not medicated, he cannot be said to have foreseen the consequences of his failing to take his medication. For instance, if the person has never experienced a violent episode before and had only presented with mild auditory hallucinations (such as hearing voices whispering to him), and risks of failing to take his medication were not successfully conveyed to him by his doctor while he was stable, then the person would quite understandably not foresee the risk in going off of his medication. However, if the person has actually experienced extreme or violent psychotic episodes in the past or has been duly warned by his physician of the serious risks of failing to medicate, as was the case with Joubert, then this should suffice to establish foresight of danger, which, if disregarded, should constitute the "marked departure" from the normal standard of care.

C. There Must Be a Breach of a Duty Imposed by Law.

The last significant hurdle to overcome in making out the offence of criminal negligence is establishing the "duty" imposed by law which is violated when one recklessly fails to take his anti-psychotic medication. The duty imposed by law may be either a common law duty or a duty imposed by statute.[99] I will put forth arguments positing a duty imposed by law under both of those avenues. If either or both of these arguments are plausible, then there is good reason to deem it criminal negligence when recklessly failing to adhere to one's anti-psychotic medication regimen results in the injury or death of another due to psychological break down, notwithstanding that the NCR defence applies to all actions taken whilst in the midst of the breakdown.

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98 See: Anders Tengstrom et al, "Schizophrenia and Criminal Offending" (2004) 31:4 Criminal Justice and Behavior 367; Jeffrey W Swanson et al, "A National Study of Violent Behavior in Persons with Schizophrenia" (2006) 63:5 Arch Gen Psychiatry 490.

99 *R v Thornton* [1993] 2 SCR 445 at paras 9 to 15.

1. Common Law Duty - Imported from Civil Negligence

The civil duty of care to refrain from acting in a manner which may cause harm to others was set out as the "neighbour principle" in the great case of *Donoghue v Stevenson*.[100] Violation of the duty of care may give rise to a cause of action in the tort of negligence.[101] Regarding the neighbour principle, Lord Atkin of the House of Lords held that

> ...you must not injure your neighbour... You must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour, [those] persons who are so closely and directly affected by my act that I ought reasonably to have them in contemplation as being so affected when I am directing my mind to the acts or omissions which are called in question.[102]

As this general principle holds, we must take care not to injure those around us whom we can reasonably foresee to be impacted by our conduct. Of course, the standard is not one of perfection, as the reasonable person need only be prudent in the circumstances, taking into account the likelihood of harm, the magnitude of potential harm, and the cost of preventative measures.[103] In many respects, this standard of care is analogous to the standard of care in criminal negligence. Based on this general rule, it seems natural that foreseeability of danger to others at the prospect of discontinuing one's anti-psychotic medication would set out the duty of care owed by him. The possibility of danger to others may vary depending on the nature of the person's mental illness, as would the potential magnitude of harm. For instance, someone with a mental disorder who has never been disposed to violence would reasonably foresee a lesser magnitude of harm (if any) to those around him if he stopped taking his medication; however, someone prone to violent outbursts when unstable ought to reasonably foresee extreme danger if he should stop taking his medication. The cost of preventative measures would be nominal (assuming the person could afford the medication or had insurance), as such measures only include adherence to the treatment regimen. If the person adheres to their regimen, then he satisfies his duty of care.

One significant issue remains before a duty of care to others would be attributed to the medicated person with a mental disorder. Courts will deny finding a duty of care in cases where public policy reasons would override the reasons to hold the person responsible.[104] For instance, in *Dobson v Dobson*,[105] the Supreme Court of Canada held that pregnant mothers do not owe a duty of care to their unborn children, despite the fact that everyone else in the world does. To hold mothers negligent in tort for injuries caused to their foetus would be to

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100 [1932] All ER Rep 1; [1932] AC 562 (HL) [*Donoghue*, cited to AC].

101 Philip H Osborne, *The Law of Torts*, 3d ed (Toronto: Irwin Law Inc, 2007) at 25.

102 *Donoghue v Stevenson*, *supra* note 100 at 580.

103 *Osborne*, *supra* note 101 at 30-34. See also *Bolton v Stone*, [1951] AC 850 (HL).

104 See *Cooper v Hobart* 2001 SCC 79.

105 (1999), 45 CCLT (2d) 217 (SCC).

unduly restrict the liberty of the mother, as she might fear taking the slightest of risks (including driving a vehicle), injuring the foetus, and being open to a negligence suit once the child is born. Similarly, someone might argue that imposing a duty of care on those with mental disorders that they must adhere to their treatment is also restrictive of their liberty interests and their autonomy. These arguments should not be compelling and do not, I think, represent an overriding public policy concern for denying the existence of a duty of care owed to others by those taking anti-psychotic drugs.

Certainly the right to refuse treatment is an important one which speaks to one's dignity and autonomy, but there is a limit to this. Respecting someone's desire to refuse treatment (or perhaps their inability to maintain treatment) might not be objectionable in cases where the person is only putting his own health at risk. The same should not be said, however, when the person is putting someone else at risk by exercising his right to refuse treatment. Recently in Manitoba, a woman was detained in jail in order to prevent the spread of tuberculosis. She had been diagnosed previously but had allegedly refused to comply with treatment orders from physicians. Given that she worked in the sex trade and thus represented a significant infection risk to others, she was detained.[106] If we are willing to detain someone in cases such as this, as she exercises her right to refuse treatment, this is arguably curtailing that right, and rightfully so, I think. Thus, the right to refuse treatment is not absolute, as we are willing to essentially, albeit sometimes indirectly, deny it outright.[107] Regardless, depending on the circumstances it may or may not be justifiable to deny the right to refuse treatment in the first place; but in any event, even if one possesses a right to refuse treatment, this does not mean that he cannot be held responsible after the fact if in exercising his right he injures or kills someone.

While they are medicated and in their stable state, people with mental illnesses would presumably be liable to any other civil negligence action, provided they could foresee the consequences of their actions. For instance, if a person with schizophrenia, whilst in the stable medication phase of his treatment, burned

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106 "Manitoba woman jailed after stopping tuberculosis treatment" The Globe and Mail (2 August 2011), online: <http://www.theglobeandmail.com/news/national/prairies/manitoba-woman-jailed-after-stopping-tuberculosis-treatment/article2117828/>. The detention was permitted by *The Public Health Act*, CCSM c P210. People with a communicable disease may be ordered to be treated or to isolate themselves (s 43(2)). Even though a person may refuse to comply with any order made under a provision of this Act (ss 43(4), 97), she may be detained if the medical officer judges her to be a threat to public safety (47(2)) and this detention may be extended indefinitely as long as the medical officer believes the person is a threat to public safety (ss 50(1), (2), (3)).

107 Arguably, the right to refuse treatment can be practically curtailed in cases where the refusal of treatment entails a threat to the public safety. Even if treatment cannot be forced upon the person as per s 97 of *The Public Health Act*, detaining the person until she "willingly" complies nonetheless diminishes the right to refuse treatment.

down his neighbour's house because he created a bonfire too close to it, (a foreseeably dangerous activity) there would be no reason to exclude tortious (or possibly criminal) liability merely because he has a mental illness. Why then should it be any different if instead the person went off his medication, knowing that it might result in a violent breakdown?

It might be argued that, for sympathetic and compassionate reasons, the mentally ill should not be held to have a duty of care owed to others which involves them mitigating their own mental illness, primarily because it might practically be a "symptom" of the disorder that they have difficulty adhering to their medication. This is not a strong argument. In *Fiala v Cechmanek*[108], a civil negligence action was brought against the defendant for his role in a motor vehicle accident. The defendant had bipolar disorder but he did not know it. It had not been diagnosed, nor had he experienced any symptoms of it. One day while out for a run he had a severe manic episode in which he ran into traffic, banged on the window of a passing car, jumped into the car through the sun roof, and proceeded to strangle the driver, causing her to crash into another car. Firstly, it must be noted that in *Fiala*, the Court was discussing the appropriate standard of care owed by the defendant. Based on the fact that a discussion about standard of care was even occurring, the Court must have been satisfied that there was a duty of care owed by him to the general public. The Court held that there had been no violation of the standard of care on the part of the defendant; but it did so noting the fact that the defendant was not aware of his mental disorder and therefore could obviously not foresee the results of failing to attend to it.[109]

The Court set out its test for avoiding tortious liability for a defendant who was "afflicted [by a mental illness] suddenly and without warning." The defendant would have to prove either that he had no capacity to appreciate his duty of care at the time or that he could not discharge his duty of care as a result of the mental illness.[110] The result of the application of the test is highly analogous to the NCR test itself, but importantly, the Court carefully noted that it can only be applied where the mental deterioration was sudden and without warning, which by negative inference one can interpret to mean that had the person been aware of their mental disorder (if it was not sudden nor without warning) then there would be liability. Notably, the Court directed its attention toward the standard of care, simply dispensing with policy concerns over whether a duty of care was owed by the mentally ill defendant.

Moreover, the "sympathy" policy argument to exclude civil liability for reckless non-adherence to anti-psychotic medication was explicitly rejected in *Wenden v Trikha*.[111] In that case, the defendant caused a car accident by driving

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[108] 2001 ABCA 169, 201 DLR (4th) 680 [*Fiala*].

[109] *Ibid* at para 49.

[110] *Ibid.*

[111] 116 AR 81, 8 CCLT (2d) 138, affirmed 135 AR 382 (CA), at paras 140-144.

dangerously, thinking that as he was driving, he was travelling through time. The defendant had discontinued use of his anti-psychotic medication. The Court held both that he was negligent in respect of his actions while he was in his disordered state, and even if he did not have the capacity to have been negligent at that time, that he was negligent in respect of failing to maintain his medication regimen. The Court emphasized foreseeability as pivotal to negligence, noting how the defendant could foresee the consequences of going off of his medication, as:

> Trikha is an intelligent person affected with a mental problem which can only be controlled by medication. ... Indeed, it seems that [the medication] had controlled the illness. I am satisfied that Trikha was told to take his medication and was fully aware of the possible consequences if he failed to do so ... [h]e knew exactly why he was to take his medication and the risk he ran if he did not.[112]

Based on the foregoing, it is clear that the duty of care imposed by civil negligence and the law of torts would include the duty to take one's anti-psychotic medication, where foreseeability of harm to others is present. Therefore, it is arguable that this duty could serve as the "duty" required by the offence of criminal negligence.

2. A Statutory Duty of Care - Common Nuisance, Equivalent to Criminal Negligence

The duty of care of tort law may be imported into the meaning of "duty" in section 219 of the *Code*; however, it is also arguable that that civil duty of care has already been grafted on to the offence of common nuisance (section 180), and is therefore a duty prescribed by the *Code* itself.

In *R v Thornton*,[113] the accused was found guilty of committing a common nuisance endangering the lives or health of the public contrary to section 176 (now section 180) of the *Code*.[114] He had been diagnosed with HIV and had been informed of, among other things, the fact that he must not donate blood because that is how HIV is transmitted. He donated blood anyway, but the tainted blood was found on testing, and the accused was charged for having created a risk to public health and safety. The *Code* sets out the offence of common nuisance as:

> 180(2) For the purposes of this section, every one commits a common nuisance who does an unlawful act or fails to discharge a legal duty and thereby
> (a) endangers the lives, safety or health, property or comfort of the public;

The term "legal duty" set out in this provision, while distinct from the wording of the "duty imposed by law" required by section 219 for criminal negligence, carries the exact same meaning;[115] therefore whatever might be said

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112 Ibid at para 141.

113 *R v Thornton* (1991), 1 OR (3d) 480 (Ont CA); affirmed (1993), 13 OR (3d) 744 (SCC).

114 *Criminal Code*, *supra* note 2, s 180.

115 *R v Thornton*, *supra* note 113 at para 14.

about a "legal duty" *vis-a-vis* common nuisance would apply equivalently to a "duty imposed by law" *vis-a-vis* criminal negligence. Referencing strong reliance on civil negligence, the Court noted that:

> there is deeply embedded in the common law a broad fundamental duty which, although subject to many qualifications, requires everyone to refrain from conduct which could injure another. ... At the very least, however, it requires everyone to refrain from conduct which it is reasonably foreseeable could cause serious harm to other persons. Accepting, as I have said, that a "legal duty" within the meaning of that term in s. 180(2) includes a duty arising at common law, I think that the common law duty to refrain from conduct which it is reasonably foreseeable could cause serious harm to other persons is a "legal duty" within the meaning of that term in s. 180(2).[116]

As evidenced by this passage, it appears as though the Court essentially transplanted the duty of care behind the "neighbour principle" from civil negligence law and made it part of the meaning of "legal duty" within section 180(2) of the *Code*. Recalling that the "duties" of section 180 and section 219 are equivalent, this must mean that the duty of care from tort law has been recognized by the Court as a "duty" which, if breached, may result in criminal negligence.

In addition to the duty of care as it is imported by section 180(2) of the *Code*, there is perhaps an even more direct statutory mechanism for finding a breach of legal duty with respect to a person taking prescribed anti-psychotic medication which is known to inhibit violence. When the *Thornton* case was appealed and received comment from the Supreme Court of Canada,[117] Lamer CJ found that the crime of common nuisance was made out via section 216 of the *Code*. Section 216 reads:

> 216. Every one who undertakes to administer surgical or medical treatment to another person or to do any other lawful act that may endanger the life of another person is, except in cases of necessity, under a legal duty to have and to use reasonable knowledge, skill and care in so doing.

Some might argue that using section 216 as a gateway to common nuisance in *Thornton* was a stretch, as donating blood is difficult to construe as administering a surgical or medical treatment to another person. That said, section 216 is broadened by the requirement to use reasonable knowledge, skill, and care, in doing any other lawful act. In any case, given that section 216 was held to in fact encompass a duty of care when donating blood, it should be ever more likely that it would also encompass a duty of care in respect of one taking (or not taking) his anti-psychotic medication. If donating contaminated blood constitutes a failure to use reasonable knowledge, skill, and care, then discontinuing prescribed antipsychotic medication outside of a controlled environment such as a hospital (which would arguably satisfy the requirement for

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116 *Ibid* at para 21 [emphasis added].

117 *Supra* note 99.

taking reasonable care) should likewise be considered a breach of the requirements of section 216. That is, section 216 can be construed to require that individuals taking antipsychotic medication (a lawful act) are under a statutory duty to do so using reasonable knowledge, skill, and care.

In summary, if, in order to establish a charge of criminal negligence, it is not desirable to find a breach of legal duty by resorting to the common law, then the legal duty which is breached by failing to take one's anti-psychotic medication may come from the *Code*. In particular, either section 180(2) (common nuisance) or section 216 (the duty to perform lawful acts with reasonable knowledge, skill, and care) might be argued.

D. The Establishment of Criminal Negligence

Based on the foregoing, there is good reason to consider the reckless non-adherence to an anti-psychotic medication as criminal negligence where that person commits a crime as a result of the ensuing psychological deterioration. I have argued that the failure to take medication can be an omission, that such an omission would be unreasonable, and that that omission would breach the duty of care owed to others. In practice, it may be difficult to establish in evidence that the accused was stable while on his medication, knew the risks associated with discontinuing it, actually did discontinue it, and that this caused the mental deterioration which lead to the violent incident.

In those difficult cases the charge of criminal negligence might fail on evidentiary grounds; however, the difficulty inherent to some cases in establishing the criminal negligence requirements I have enunciated should not be fatal to the argument at hand. There are undoubtedly many cases where such evidence can be adduced. As happened in the *Joubert* case, a person's struggle with medication adherence, as well as their mental state when on and off the medication, may be well known to the person's family, friends, physician, or neighbours. If such people are canvassed and indicate that medication adherence was a probable factor in what turned out to be the NCR offence, the crown may proceed with a criminal negligence charge. The accused himself may also wish to testify (and thus be open to cross-examination) in regard to his medication adherence if the Crown makes the medication an issue.

VII. SPECIFIC PUNISHMENT

It is not the aim of this paper to explore the logistical factors around the sentencing of one guilty of criminal negligence in the circumstances of reckless exacerbation of a mental disorder. Whether a new trial would have to occur or whether the Crown could simply accept an NCR plea and re-charge the accused with the criminal negligence (a lesser offence with a lesser punishment) is a

logistical issue which, though admittedly important, I do not consider here. Also important but omitted from discussion here is the impact from the *Charter*,[118] though any such impact may be negligible as long as the punishment is commensurate with the culpability involved in the offence.[119]

For context, it is useful to consider what happens to someone who successfully pleads the NCR defence. Once the trier of fact has determined that the accused was indeed suffering from a mental disorder which deprived him of the ability to appreciate the nature of his actions or know that they were wrong, a verdict of "not criminally responsible on account of mental disorder" is rendered.[120] At this point, the court may make a disposition of the accused or refer the accused to the review board. Both the court and the review board have the power to discharge the accused absolutely where they find the accused not to be a danger to society. Alternatively, they may discharge with conditions or they may order detention in a psychiatric facility. In all events, the court and review board must make the least onerous disposition possible, balancing public safety and the liberty of the accused.[121] Notably, this means mentally ill people may be released provided they do not pose a safety risk. One does not have to be "cured" to be released.

If detained or subject to a conditional discharge, the review board must hold a review hearing at least once per year to determine if the accused is fit for release. If, however, the accused was found NCR of a serious violent offence and the review board has information indicating that the accused is not likely to improve, then it may extend the period between reviews.[122] Presumably, the review board would take into account an accused's ability and history of medication adherence in determining when he is fit for release. What this means is that an accused who pled the NCR defence and who is currently dangerous will not be released and public safety will not be an issue. Thus, there is no "public safety" justification to punishing an accused for his criminal negligence in discontinuing his medication, and adding jail time on top of time spent in a psychiatric institution would seem not to be rehabilitative at all. Yet the accused was reckless and as a result someone else was hurt or killed, and for this some punishment ought to result, despite the culpability of the accused being less than that of a regular assault or murder.

As noted earlier, it is a fundamental principle of law that "[a] sentence must be proportionate to the gravity of the offence and the degree of responsibility of the offender."[123] As well, the Court should consider alternate sentencing options taking into account the circumstances of the offender.[124] There is also the fact

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118 *Charter*, *supra* note 29.

119 *Creighton*, *supra* note 91 at para 99.

120 *Criminal Code*, *supra* note 2, s 672.34.

121 *Ibid* s 672.54.

122 *Ibid* s 672.81(1) and 672.82(1.2).

123 *Ibid* s 718.1.

that, as a matter of logic, the punishment for criminal negligence in this case should not be severe. It would make little sense to allow the person to (rightly) plead the NCR defence in respect of a murder he had committed while in the throes of his disorder and thus allow him to avoid penal sanctions for the murder, only to turn around and charge him with criminal negligence for failing to take his medication and subsequently punish him just as we would have for the murder had he not been NCR. What, then, are the alternatives?

To be sure, critics of the justice system, who find little utility in incarcerating offenders generally, will likely not find any utility in incarcerating someone who intentionally exacerbated his own mental disorder and who is now in a mental health institution. Indeed, not only would incarceration in a prison be unhelpful for the continued rehabilitation of the person, but it would in all likelihood be counterproductive to that goal. On the other hand, do we not think it proper to punish a drunk driver who caused the death of a pedestrian in a crash, even if, as a result of the accident, the drunk driver himself was rendered a paraplegic? There would be little danger of the paraplegic ever driving drunk again, and so there is no public safety value in punishing him. Provided that the drunk driver was remorseful, any prison time would be purely retributivist and serve only to denounce the conduct and make the public feel that justice was served. In spite of his misfortune, I think it is still proper to hold him accountable for his crime, albeit that we might be more lenient in sentencing. Likewise, acknowledging the crime of pre-NCR actions of a now-NCR individual should be warranted, with leniency in sentencing if appropriate.

I stress again that the ambit of this paper is to argue that there are good legal and philosophical reasons to punish reckless non-adherence to anti-psychotic medication. That is, I have argued that something should be done. What I have not considered is what exactly should be done, as answering that question would require extensive investigation into the logistics and arguments over how to conduct trials and sentencing. Several possibilities exist in terms of punishment options which ought to be investigated. As a starting point, community service or a conditional sentence would seem to be appropriate possibilities which both recognize the culpability of the offender with respect to his pre-NCR conduct, yet are not so onerous or restrictive of liberty so as to undermine the intended and proper exculpatory effects of the NCR defence with respect to the accused's NCR conduct. Rather than simply forgetting about the culpability of recklessly or intentionally discontinuing medication, the wrongful conduct of the offender is recognized and the punishment is tailored to suit the level of culpability.

Someone who failed to inhibit a psychotic episode because he discontinued medication that made him feel unpleasantly lethargic should be convicted of criminal negligence if he thereby seriously injured or killed someone; however,

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[124] *Ibid* s 718.2(e).

when it comes to sentencing, he should not be regarded as having coldly and purposefully engaged in dangerous conduct. His culpability is less, and so too should his punishment be less. On the other hand, where the accused had wilfully and belligerently refused to comply with his medication regimen, had an improper purpose for doing so (if he hoped that his instability would spur him to commit a crime), or if he is a repeat offender in these circumstances, then it seems that prison time for criminal negligence, even in excess of time spent in a psychiatric institution, would be a warranted punishment in light of the obvious and severe pre-NCR culpability.

VIII. CONCLUSION

From both a legal and philosophical point of view, it seems that there is good reason in principle to sanction mentally disordered persons where, while in a stable state, they recklessly exacerbate their own mental disorder and injure or kill others in the process. A historical accounting of "insanity" defences as well as current statute and case law on the subject indicates that the NCR defence is meant to be localized to the time frame when one is in the throes of his mental disorder, and does not include the period of stability in which he decides to go off of his medication. The elements of the charge of criminal negligence are made out, as foreseeability of harm resulting from discontinuing the medication regimen both establishes a duty of care, originating either from the common law of torts or from the codified offence of common nuisance. The breach of such duties, in light of foresight of the consequences, represents a marked departure from the normal conduct of the reasonable person, and thus one may be criminally negligent where he injures or kills another as a result of his earlier reckless omission.

A significant question remains insofar as what the appropriate punishment of such offenders should be. Naturally, the punishment should vary accordingly with culpability, which may be minor if the accused was heavily influenced by the side effects of his medication or major if the accused was capricious or wilful in his neglect.

One might call into question the true utility and necessity of punishing those with mental disorders who, when they are in control, act recklessly in respect of them, might be called into question. It must be remembered, however, that the integrity of the NCR defence is best served by denouncing recklessness concerning abatement of mental disorders. The NCR defence is not an automatic blanket defence for anyone with a mental disorder, and those with mental disorders do not receive immunity from the law in all other respects. It is important that the fostering of perceptions to the contrary be avoided, and one way to do this is to hold people with mental disorders responsible for recklessness perpetrated while they were in their stable state. Being that, in this stable state,

people with mental disorders may not appeal to the NCR defence, and thus the *mens rea* of any crime they commit during this period is as unblemished as it would be for anyone else, then it makes sense to hold them accountable for crimes committed in this state, including criminal negligence. Arguably, failing to abate one's own mental disorder when the consequences of doing so are potentially dire and known to the individual, constitutes criminal negligence if death or injury results. Even though the NCR defence is available to an accused who exacerbates or fails to abate his own mental disorder, it should not function to retroactively exculpate him for his conduct before he would be considered NCR.