Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing: Criminal Responsibility

Lisa Ramshaw, MD, DPhil, FRCPC[1]; Treena Wilkie, BScH, MD, FRCPC[1]; Todd Tomita, MD, FRCPC[2]; Graham Glancy, MB, ChB, FRCPsych, FRCPC[1]; Sumeeta Chatterjee, MD, FRCPC[1]

The authors would like to thank the National Working Group (Todd Tomita, Alberto Choy, Mansfield Mela, Jeff Waldman, Richard Schneider, Brad Booth, Jocelyne Brault, Mathieu Dufour, and Aileen Brunet) for their essential contributions. The authors would also like to thank their expert reviewer, Hy Bloom.

Reviewed and approved by the Canadian Academy of Psychiatry and the Law (CAPL) Board of Directors on August 30, 2021.

STATEMENT OF INTENT: CAPL Resource Guide for Reference and Training

This document is intended as a review of legal and psychiatric principles to offer practical guidance in the performance of forensic evaluations. This resource document was developed through the participation of forensic psychiatrists across Canada, who routinely conduct a variety of forensic assessments and who have expertise in conducting these evaluations in various practice settings. The development of the document incorporated a thorough review that integrated feedback and revisions into the final draft. This resource document was reviewed and approved by the Board of CAPL on August 30, 2021. It reflects a consensus among members and experts, regarding the principles and practices applicable to the conduct of forensic assessments. This document does not, however, necessarily represent the views of all members of CAPL. Further, this resource document should not be construed as dictating the standard for forensic evaluations. Although it is intended to inform practice, it does not present all currently acceptable ways of performing forensic psychiatry evaluations and following these guidelines does not lead to a guaranteed outcome. Differing facts, clinical factors, relevant statutes, administrative and case law, and the psychiatrist's clinical judgement determine how to proceed in any individual forensic assessment.

This resource document is for psychiatrists and other clinicians working in a forensic assessor role who conduct evaluations and provide opinions on legal and regulatory matters for the courts, tribunals, and other third parties. Any clinician who agrees to perform forensic assessments in any particular domain is expected to have the necessary qualifications according to the professional standards in the relevant jurisdiction and for the evaluation at hand.

See the *Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing: General Principles*, which will apply to all of the guidelines and will not be repeated below.

OVERVIEW OF CRIMINAL RESPONSIBILTY

The underlying principle that an individual must have the ability to understand that their behaviour was wrong in order to be found guilty of a criminal offence is a foundational concept in the Canadian judicial system. (1,2) A judge or jury will find a person not criminally responsible on account of mental disorder (NCR) if, while committing an offence, the accused was suffering from a mental disorder that was sufficient to render them incapable of appreciating the nature and quality of the act or omission or of knowing that it was wrong.

The basis for this alternate verdict of NCR (that is, neither an acquittal nor a finding of guilt [section 672.34]) avoids an unfair conviction of an accused person who satisfies the

criteria for being not criminally responsible on account of a mental disorder. The Canadian judicial system has chosen to identify and address the population of offenders with a mental disorder differently, using the principles of therapeutic jurisprudence, risk, recovery, and reintegration.

The alternate verdict of NCR can be contentious in the eyes of some if it is perceived that such a finding serves to exonerate an individual from their crimes or if it is based on a person "faking mental illness" to achieve this verdict. However, an NCR verdict is not a "get out of jail free" card, which is sometimes the public perception. These concerns highlight the importance of a rigorous process of assessment and the reporting of assessment findings. The NCR process is not based on a punitive form of justice but on a restorative one that has been shown to significantly decrease the risk of re-offending, compared to standard judicial processes, (3,4) and involves a legislated process that ensures engagement with victims throughout. An NCR finding puts offenders onto an alternate pathway under the provincial or territorial review board, where they are typically subject to liberty restrictions (for example, a detention order in a forensic hospital or supervision in the community) and rehabilitation that is necessary and appropriate to manage their risk to the public and reintegration into society (see the *Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing: Violence Risk Assessment*). An assessment based on a sound forensic methodological approach will usually identify those who attempt to fake illness (i.e., malingering) or attempt to exaggerate or minimize symptoms in the service of seeking an alternate verdict of NCR.

According to Statistics Canada, (5) adult NCR cases in Canada accounted for less than one per cent of the total number of adult criminal court cases processed per year between 2005 and 2012. Nearly two-thirds of NCR cases involved crimes against the person (compared to about one-quarter among non-NCR cases), with major assaults being the most frequent offence. (2) The NCR populations tended to be slightly older and more often men than their non-NCR counterparts (34 versus 31 years of age and approximately 13% versus 19% women in NCR and non-NCR cases, respectively). (2) Similar to the non-NCR offending population, there is an over-representation of visible minorities among NCR cases. According to the National Trajectory Project, which examined people under review boards in British Columbia, Ontario, and Quebec, (3,4) there are significant interprovincial differences in those found NCR with regard to time detained in hospital and time under the supervision of a review board. The project found that 79% of those found NCR are still detained in hospital after five years in Ontario, compared to only 23% still in hospital after five years in Quebec. This research showed that the three-year recidivism rate post-index offence was 10% in Ontario; the highest rate in Canada was 21.5% in Quebec. They also demonstrated that among those who had committed a severe offence, there was only a 6% recidivism rate of any kind and a 0.6% recidivism rate involving a severe offence. The authors note that these figures should be compared with the general recidivism rate in the same period (34%) and for an inmate population treated for mental disorder and released, which was 70%.

Criminal Responsibility Orders and Assessments

The issue of criminal responsibility may be raised by the accused at any stage of the trial process, even after a finding of guilt, but prior to conviction or sentencing. The Crown might also raise the issue of criminal responsibility independently over an accused's objections, thereby protecting an accused from potential unfair conviction. (6,7) A common-law rule arose from the Supreme Court of Canada's *R v. Swain* (8) decision in 1991, which stipulated two junctures at which the Crown can raise the issue of NCR over the accused's objection: 1) if the accused puts their own mental capacity at issue in the course of their defence or 2) after a finding of guilt.

The court should not on its own motion raise the NCR defence. This question was addressed by the BC Supreme Court in *R v. Piette,* (9) which found that to do so deprived the accused of their constitutional right to control their defence at trial. Although NCR cases often proceed as a single hearing, where guilt and NCR are determined at once, a "bifurcated trial" might occur instead. In this case, the first trial focuses on guilt beyond a reasonable doubt, which allows for an accused to use defences other than NCR. Later, and only if found guilty by the trier of fact, would the second trial establish whether the burden of an NCR defence has been met on the "balance of probabilities."

All accused who are found guilty of a crime are assumed to be criminally responsible for their actions unless proven otherwise on a balance of probabilities. The Criminal Code of Canada (section 16[3]) stipulates that, "The burden of proof that an accused was suffering from a mental disorder so as to be exempt from criminal responsibility is on the party that raises the issue." (10)

Under subsection 672.11(b) of the Criminal Code, "A court … may order an assessment of the mental condition of the accused, if it has reasonable grounds to believe that such evidence is necessary to determine criminal responsibility." (11) The assessment can be conducted by any medical practitioner or qualified person designated by the Attorney General, though in practice, this tends to be a licensed psychiatrist (generally a forensic psychiatrist in most provinces and territories). The order may be issued by means of Form 48. These assessments can occur on an inpatient or outpatient basis and typically for no more than 30 days (subsection 672.12[1]), although this can be extended to up to 60 days (subsection 672.14[3]) in compelling circumstances.

The Criminal Code of Canada's NCR Test

The defence of NCR came into effect pursuant to Bill C-30 in 1992 and replaced what was previously referred to as the "insanity defence." s 16(1) of the Criminal Code states:

> 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. (12)

It is important to note that Canada's NCR test is a legal test, not a medical one. As in many areas of forensic psychiatry, the assessor is tasked with providing a psychiatric opinion within a legal framework in which medical and legal constructs may not be perfectly aligned.

There are five components of the NCR analysis that are addressed individually:

1. Did the accused suffer from a mental disorder at the time of the alleged offence?
2. What symptoms and functional impairments were produced by the mental disorder at the material time?
3. Did the symptoms and functional impairments interfere with the accused's ability to appreciate the nature and quality of the act or omission?
4. Did the symptoms and functional impairments interfere with the accused's ability to know the wrongfulness of the act (either legally or morally)?
5. Did the symptoms and functional impairment impact the accused's ability to engage in rational decision-making at the material time?

Did the accused suffer from a mental disorder at the time of the alleged offence?

The presence of a mental disorder at the time of committing the index offence is necessary but not sufficient for a finding of NCR. A mental disorder is defined in the Criminal Code as a "disease of the mind." This legal definition, as described in *R v. Cooper,* (13) articulates "mental disorder" as embracing "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." What constitutes a mental disorder is a difficult concept and the subject of discourse in the field of psychiatry as well as the law. Examples of mental disorders that may result in successful NCR findings include schizophrenia, bipolar disorder, major depression with psychotic features, intellectual disabilities, and neurocognitive disorders. While forensic psychiatrists have expertise in psychiatric diagnoses, ultimately the court will determine if the disorder fits the legal concept of a disease of the mind and so instruct the jury. (13,14)

This question of a mental disorder was carefully considered in the setting of self-induced intoxication in *R v. Bouchard-Lebrun.* (14) The Supreme Court adopted the legal analysis derived from *R v. Stone* (15) using two analytic tools, namely, whether the condition was caused by an internal factor, which differentiates the accused from a person without the disorder, or an external factor, such as a blow to the head or, in some cases, self-induced intoxication. The court also reaffirmed that, as was noted in *R v. Parks,* (16) one function of the NCR defence is to protect the public from recurrent danger; hence, policy considerations that consider whether there is a likelihood of recurrent danger resulting from the disorder are a second major issue. As was noted in *R v. Minassian,* (17) conditions that are permanent, have an organic or genetic cause, and are recurring are more likely to qualify.

What symptoms and functional impairments were produced by the mental disorder at the material time?

It is insufficient for an accused to suffer from a mental disorder in general. Rather, there must be evidence that they had symptoms of the mental disorder at the time of committing the offence; these mental disorder symptoms need to have caused demonstrable psychiatric functional impairment. The assessor must establish a nexus among the symptoms, psychiatric functional impairments, and how the index offence unfolded. The forensic assessor needs to describe how these symptoms and related impairments impacted the accused's capacity to either appreciate the nature of their actions or know the wrongfulness of the same, as described below.

Did the symptoms and functional impairments interfere with the accused's ability to appreciate the nature or quality of the act or omission?

The forensic assessor must determine whether the accused was incapable of appreciating the nature and quality of their action or omission. The task of "appreciating" is different from "knowing" in the second branch of the test. Appreciating is a multifaceted capacity that requires an accused to have an emotional and intellectual awareness of the significance of the act. (13,18) However, in other cases, the nature and quality of an action have been interpreted to mean the physical consequences of the act. (19,20) In practice, an NCR defence based on this branch of the test is less common, as even individuals with severe psychosis are often capable of knowing the physical consequences of the act. Cases fitting this branch of the test more commonly involve significant levels of confusion, disorganization, or cognitive impairment.

Did the symptoms and functional impairments interfere with the accused's ability to know the wrongfulness of the act (either legally or morally)?

Finally, even if an accused was capable of appreciating the nature and quality of their actions, the assessor must determine whether, on account of the symptoms of their mental disorder, the individual knew their actions were wrong at the material time. Wrongfulness, as defined in *R v. Chaulk, (*21) refers to either legal or moral wrongfulness. This arm of the test tends to be the more common route to an NCR finding; for example, unlawful acts are frequently driven

by delusions that compel an individual to act in a way they believe is essential to protect themselves or their loved ones or that they perceive to be the greater good.

Meeting the NCR criteria based on not knowing the moral wrongfulness of one's actions may give rise to some concern that this defence would be advanced by people who engage in criminal acts based on their personal moral code, deeming harm to others permissible, as might be the case with those with antisocial personality disorder or psychopathy; however, this rationale is insufficient. It is not the accused's personal moral code that applies; the measure is whether they are capable of knowing that society would view the act as morally wrong. The court must determine whether the accused was incapable of knowing that his acts were wrong according to the ordinary moral standards of reasonable members of the community.

The tests of knowing wrongfulness are specific to the criminal act and the accused's mental state at the material time. A complicated scenario may arise if the accused has a general understanding that a criminal act is wrong but was unable to apply this knowledge during the commission of their offence, due to the nature and intensity of their symptoms. In such situations, the accused might have lost the ability to engage in a rational choice, due to symptoms of their mental disorder, which impaired their knowing of wrongfulness. (22) While "knowing" implies a lower level of cognitive decision making than "appreciating," *Oommen (*22) suggests that mental illness that deprived the accused of the capacity for rational perception and, hence, rational choice about the rightness or wrongness of the act embraces not only the intellectual ability to know right from wrong but also the capacity to rationally apply that knowledge to the situation at hand. A clinical example is a person with acute psychosis, with a mental state characterized by disinhibition, agitation, and delusional ideation, who engages in an impulsive act of reckless violence. Although this individual might have had a theoretical understanding of wrongfulness through the distorted lens of their mental state, they were unable to rationally apply this understanding to their decision-making at the material time.

The Canadian NCR defence does not include the "irresistible impulse" defence seen in some American jurisdictions. (23)

Special Considerations

Amnesia

Partial or complete memory loss (real or feigned) for events that occurred at the time of the commission of the index offence does not directly relate to the ultimate question of criminal responsibility, as the assessment of this issue centres on an individual's mental state at the material time, rather than their understanding of the event retrospectively. Research has shown there is an increased self-report of amnesia that is proportionate to the severity of the violent offence. (24,25)

Although one might assume that a claim of memory loss is intentional misrepresentation, there are also valid psychiatric causes. These can include substance intoxication, profound physical trauma, severe cognitive disorganization flowing from acute psychosis, extreme emotional arousal and dissociation, intellectual disability, or a neurological condition. Careful scrutiny should be given to reports of complete amnesia around the time of the index offence alone, especially if it is predicated on psychological sequelae of trauma.

The assessor must therefore be vigilant in using the general principles of forensic assessment to arrive at their conclusions. This requires contemplation of the reliability of an accused's self-report; integration of multiple sources of information, including objective physical and psychological testing; and a rigorous assessment of malingering or symptom exaggeration or minimization prior to arriving at a final analysis.

Uncommon Mental Disorders

Common mental disorders seen in NCR verdicts noted earlier include schizophrenia, delusional disorder, bipolar disorder, depression with psychotic features, and organic mental disorders, such as dementia or delirium. This is not a complete list, especially when considering uncommon or potentially contentious mental disorders (e.g., sexsomnia). The matter is made more complex by the differences in how the legal and medical professions define mental disorder and debate the voluntariness of conduct flowing from these disorders, the increasing biological science behind various conditions, and the unclear risk of recurrence of some conditions. In Canada, the legal definition of *mental disorder* is very broad (as indicated in *Cooper* [13]). Generally, the necessary but not sufficient pre-condition of mental disorder is not in dispute but rather the impact that the disorder had on the accused at the relevant time. These discussions are important, nuanced, and beyond the scope of these guidelines. Canadian courts have generally adopted the Daubert standards when assessing novel science, (26) which cover the following:

- Whether the theory or technique can be and has been tested
- Whether the theory or technique has been subjected to peer review and publication
- The known or potential rate of error or the existence of standards
- Whether the theory or technique used has been generally accepted

Below are examples of disorders that are often controversial and would usually not qualify for an NCR defence absent comorbid major mental disorders, such as a primary psychotic disorder:

- Substance intoxication
- Anxiety disorders
- Posttraumatic stress disorder (PTSD)

- Dissociative disorders
- Mild intellectual disabilities
- Personality disorders and impulse-control disorders
- Sexual disorders
- Sleep disorders
- Autism spectrum disorders

Automatism

Automatism has long been debated within criminal proceedings by both medical and legal professionals due to its various inherent complexities. Further, automatism is a legal concept, not a medical concept. (27) The court recognizes automatism as unconscious, involuntary behaviour in a person who, while capable of action, is not conscious of what they are doing. (28) Alternatively, the person is conscious of what they are doing but has no control. They are a "spectator." All criminal offences have two components: an *actus reus* and *mens rea*. The act, or *actus reus*, must be voluntary. This is where automatism operates. A defence of automatism is not contained within the Criminal Code of Canada, though it is addressed in common law.

Two types of automatism are recognized by the court: mental disorder and non-mental disorder. The language of "mental disorder" versus "non-mental disorder" automatism has its roots in what was previously referred to as "insane" versus "non-insane" automatism. (15,16) The court differentiates between these two types of automatism by way of a two-step process. The first step is for the trier of fact to determine whether there is sufficient evidence to prove the individual acted involuntarily by reason of automatism. If the first step is met, it must then be determined if the cause for automatism was due to a mental disorder or some other external cause akin to a psychological blow that triggered a state of shock (rendering a finding that the individual was in a state of non-mental disorder automatism at the material time). A person found to have acted involuntarily based on automatism resulting from a mental disorder will follow the same path as one who has been found to be NCR. In contrast, non-mental disorder automatism can lead to an acquittal. In deciding between the two types of automatism, the trier of fact often considers whether the state was caused by internal or external factors and whether the individual presents a recurring risk of danger to others. (14) This framework may contain an implicit bias to viewing mental disorder automatism as being dangerous and non-mental disorder automatism as being essentially benign with no recurring risk. (6)

Automatism states may be the result of biological or psychological disturbances. Although a complete discussion of such disturbances is beyond the scope of these guidelines, below is a list of some conditions that have been recognized by the courts as causing a state of automatism. The list duplicates some of the conditions listed in the previous section because, once again, there is a shared pathway between mental disorder automatism and a defence of NCR.

The list of conditions potentially associated with automatism includes:

- Psychosis
- Neurological disorders (e.g., brain tumour, epilepsy, dementia)
- Head trauma
- Sleep disorders, including sexsomnia
- Dissociative states
- Hypoglycemia
- Substance use and substance-induced states

An interpretation of common law governing the scope of such defences is complex, sometimes contradictory, and ever-evolving; for example, in the Supreme Court case of *R v. Daviault*, (29) self-induced intoxication was excluded from a defence against a charge of assault on another person. However, in 2020, the Supreme Court struck down this finding in *R v. Sullivan* (30) on the basis that it violated principles of justice and was antithetical to the presumption of innocence if a person does not have the will or voluntariness to commit the act. (31) There will undoubtedly be more action to come regarding this issue, which underscores the need for the forensic assessor to be informed of the laws that govern the field but humble in their interpretation, which is ultimately the role of the court.

Consequences of an NCR Finding

Prior to February 4, 1992, an individual found not guilty by reason of insanity (NGRI) faced indeterminate confinement at the pleasure of the Lieutenant Governor. In the 1991 decision in *R v. Swain*, (8) the Supreme Court of Canada found that failure to stipulate a time within which an accused's liberty status must be considered ran afoul of Charter guarantees. Other related statutory provisions were also found to be suspect. As a result, the legislation was sent back to Parliament to be rewritten, resulting in Bill C-30, which was proclaimed on February 4, 1992. (6) Bill C-30 codified a new procedure by mandating annual reviews by a tribunal and the provincial and territorial review board and by setting out a legal test for how an individual could be discharged from the forensic system. The landmark case *Winko v. British Columbia* (11) placed the onus on the board to make a positive finding that an accused is a "significant threat to the safety of the public" (codified in section 672.54 of the Criminal Code). If a significant threat is not established, the accused is entitled to be discharged absolutely.

To elaborate, following an NCR verdict, an accused person is typically referred to their provincial or territorial review board, whose task it is to determine if the individual is a significant threat to the safety of the public and, if so, what disposition is necessary and appropriate to manage their risk. There are three dispositions that may be considered by the review board: a detention order, a conditional discharge,

Table 1. Psychiatric Interview Content for Criminal Responsibility

- Personal history (childhood, antisocial conduct, family, education, occupational, relationship, sociocultural factors) and self-concept
- Psychiatric history
  - Impact of active symptoms on previous behaviour
  - Relevant psychiatric history after the index offence
- Medical history
- Substance use history
  - Impact on psychiatric symptoms and use around material time
- Family history
- Legal history
  - Details of any violent offences and associated mental states
- Review of index offence(s) (see Table 2)
  - Self-reported, unsolicited (and desired outcome)
  - Prompted questioning/challenges
  - Compliance with treatment around the material time
  - Review of similar behaviours outside the index offence
- Review of symptoms/mental status examination

and an absolute discharge (the latter being issued if significant threat cannot be proven). A court shall conduct a disposition hearing upon a verdict of NCR where either party requests; however, the court will only render a disposition when satisfied that it can readily do so. A disposition should be made without delay. If the court issues a conditional discharge or detention order, the case must still be heard by the review board within 90 days. Alternatively, where the court does not make a disposition, the review board must hold a hearing *and* issue a disposition within 45 days. In both scenarios, the review board addresses the issue of significant threat and the necessary and appropriate (and least onerous and least restrictive, as per *R v. Ranieri* [32]) disposition to manage the individual's risk to the public.

THE CRIMINAL RESPONSIBILTY ASSESSMENT

Settings for Assessments

Criminal responsibility assessments can occur in a variety of settings, including an inpatient hospital setting, an outpatient setting, or a detention centre. Over time, more video-conferencing options have become available.

Sources of Information

Sources of information for assessments can vary. Assessments generally include an interview with the accused, disclosure from the office of the Crown attorney (which typically includes offence synopses, police notes, police interviews [audio or video] with the accused post-arrest, surveillance videos, witness statements, correctional records, and a criminal record), collateral interviews with those who have had contact with or knowledge of the accused, academic and employment records, files from care providers, and prior independent medical evaluations. The assessor may need to guide the referring party in the gathering of such material and advise when there is insufficient information.

While the assessor is entitled to engage in collateral interviews and seek out additional sources of information through the authority of the assessment order or retaining party, they will usually attempt to gain consent from the accused first. In some cases, getting permission from the retaining party might also be advised. The assessor may also wish to interview the victim. Judgement is required on how best to proceed (see the *Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing: General Principles*).

Psychometric measures are commonly used and might address such issues as psychopathology; symptom fabrication, minimization, or exaggeration; and cognitive functioning.

The Interview

At the outset of the interview, the assessor addresses the potential need for an interpreter, as well as any cultural or religious factors that might impact how the assessment is approached. The breadth and depth of the assessment will reflect the complexities and nuances of the case and the accused's response style. The assessment begins with a caution to the accused on the nature and purpose of the assessment, the limits to confidentiality, that the information they provide may be included within a report, and that they have the right to refuse to answer questions or participate in the assessment. In the case of court-ordered assessments, the accused can be made aware that the information provided is "protected," as per section 672.21. The format of the interview(s) covers all major domains, as noted in the *Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing: General Principles*. See Table 1 for interview content.

The central question of criminal responsibility necessitates in-depth inquiry into the accused's mental state at the time of the act, with a focus on the four parts of the NCR test noted above. See Table 2 for examples of the types of questions posed. Common symptoms that justify an NCR finding may include delusions, hallucinations, and cognitive symptoms (confusion, disorganization, and extreme disinhibition). The issue of malingering is explicitly addressed when conducting a criminal responsibility

assessment. This includes an exploration of consistency and validity of symptoms at the material time, as well as the accused's desired outcome and how that might impact their presentation during the assessment (see the *Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing: General Principles*).

When considering branches of the NCR test, determining whether a mental disorder was present and whether symptoms were present at the material time may be more straightforward than determining whether the accused appreciated the nature and quality of their actions or knew the wrongfulness of same. See Table 3 for examples of questions that can be used to address these issues.

Other Testing

The assessor will commonly use standardized psychometric measures to provide more objective information about the accused in three broad domains:

- Psychopathology (personality disorder or major mental illness)
- Cognitive functioning
- Malingering or symptom exaggeration/minimization

Please refer to the *Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing: General Principles* for more details.

Table 2. Questions Addressing Mental State at the Time of the Index Offence

- What was the overall context of the offence (e.g., personal circumstances, stressors, personal and professional supports, living and employment arrangements, engagement with care providers)?
- Did the accused suffer from a mental disorder at the material time?
- Was the accused in the care of a mental health professional prior to or at the time of the allegations?
- Was the accused prescribed/taking psychotropic medications prior to/at the time of the allegations?
- What were previous diagnoses? Medications? Treatment contacts?
- Is there a history of other acting out/criminal behaviour with logical nexus to a mental disorder?
- Was there evidence of a mental disorder preceding the index offence?
- Did the symptom profile or treatment change proximal to the offence?
- What, if any, were the symptoms of this mental disorder at the material time?
- Was there any identification by witnesses to their mental state proximal to the material time (personal and professional sources)?
- What was the role of their mental illness in driving their behaviour?
- What were their thoughts and feelings towards the victim and was there pre-existing animosity?
- Was planning evident prior to the commission of the offence?
  - If so, was the planning motivated by paranoia?
- Were there rational motives that could explain their actions?
- Were they under the influence of substances?
  - What role did substance use play in the individual's mental state and behaviour at the material time?
- Were their actions in keeping with a similar pattern of behaviour that constituted prior offences committed?
- Did they appreciate the physical consequences of their actions?
- Did they appreciate the nature and quality of their act or omission?
- Did they know their actions were legally and morally wrong?
- Did they know that a reasonable member of society would view their actions as wrong at the material time?
- What alternative actions did they consider at the material time?
  - Why did they not pursue these alternatives?
- Did the accused take any steps to cover up their actions or attempt to avoid detection?
- What were other post-offence behaviours?
- What is the accused's view of being found NCR or their criminal responsibility (recognizing that this can impact their narrative)?

Ask about contradictory file information.

Table 3. Questions Addressing the Accused's Ability to Appreciate and Know the Wrongfulness of Their Actions

- What happened?
- What led to that happening?
- What were you thinking and feeling at the material time?
- What did you expect would happen to the victim?
- How did the victim react?
- What did you want to happen to the victim?
- If a person did what you did, what would happen to the victim and how would the victim feel?
- If religious: What did you think (e.g., God, your priest, rabbi, imam) would think of your actions?
- How would others in your community judge your actions?
- What made you make that choice?
- Did you know your actions were illegal?
- Did you worry about getting caught?
- What did you think would happen when the police found out?
- Did you try to hide your actions? If so, how, and what was the reason?
- Where did your right to do what you did come from?
- What alternative actions did you consider at the time? Did you carry out any of these alternatives? Why or why not?
- Should you have done what you did?
- What would have happened if you hadn't done it?

*Adapted from Bloom and Schneider (6) and Glancy and Regehr. (33)

THE CRIMINAL RESPONSIBILTY REPORT

The criminal responsibility report is similar to other forensic assessment reports (see the *Canadian Guidelines for Forensic Psychiatry Assessment and Report Writing: General Principles*). Its length varies depending on the complexity of the case and the volume of information available. The order of the various headings might also vary, depending on the preference of the assessor. The report should cover all areas of inquiry noted above. See Table 4 for an example of a criminal responsibility report template.

Within the analysis of criminal responsibility, the four branches of the NCR test are explicitly addressed. This includes whether the accused suffered from a mental disorder, if symptoms of this disorder were present at the material time, and if there was a nexus between the accused's symptoms and their capacity to appreciate the

Table 4. Example of a Template for the Criminal Responsibility Report

- Referral source (court-ordered or defence requested)
- Reason for assessment
- Sources of information
- Preliminary caution regarding consent and confidentiality
- Identifying data
- Index offence
  - File information
  - Collateral sources
  - Self-report
- Legal history and other police contact
- Personal and developmental history
  - Childhood and family history
  - Education and employment history
  - Antisocial conduct history
  - Relationship history
  - Sociocultural factors
- Medical history
- Substance use history
- Psychiatric history and treatment
- Family psychiatric history
- Review of symptoms and mental status examinations (and fluctuations)
- Standardized psychometric testing results
- Psychiatric opinions and recommendations
  - Limitations
  - Summary of history (inclusion of this varies)
  - Diagnosis and clinical formulation (including the impact of sociocultural factors)
  - Criminal responsibility analysis, anchored in the branches of the Criminal Code of Canada test, as well as:
    - Relationship between their illness and the behaviour and affective state
    - Potential impact of substances and/or treatment at the time
    - Prior description of similar circumstances/ behaviour
    - Context and motivation for behaviour
    - Review of competing hypothesis that might otherwise explain the behaviour (including any reality-based motivation, prior animus, impact of desire to be found NCR or not, and malingering)
  - Mandatory reporting issues, as relevant
  - Recommendations (see below)
- Signature block

nature and quality of their actions or to know if their actions were legally or morally wrong. The analysis also addresses alternative hypotheses for the commission of the offences (e.g., driven by anger or revenge, personality vulnerabilities, or substance intoxication) and whether there are concerns about symptom fabrication or malingering. In attempting to reconcile potentially competing theories (for example, psychosis versus underlying *animus*), the assessor may conclude (often on the basis of a balance of probabilities), that the weight of information, examined from a psychiatric perspective, favours one theory over another. Critically, the court should always have the benefit of understanding the expert's rationale for preferring or dismissing one theory over another.

The manner in which an assessor addresses the ultimate issue of criminal responsibility varies. Although the finding is a matter for the trier of fact, many assessors will provide an opinion from a psychiatric perspective. At times, there may not be sufficient information or different scenarios might alter opinions on the ultimate issue of criminal responsibility. These nuances, limitations, and caveats are delineated in the assessor's report.

The extent to which an assessor offers recommendations will vary. Some assessors may choose to include broad treatment recommendations, while others may prefer to opine strictly and only on the psycholegal question at hand. Recommendations will vary depending on local custom, any direction or requests from the court, and the assessor's preference. Some judges might indicate any areas they do not want the assessor to address. Notably, a criminal responsibility assessment is not a risk assessment. If an individual is found NCR, some assessors may recommend a referral to the review board, where a risk assessment can then determine the necessary and appropriate disposition.

Author Affiliations

[1]Department of Psychiatry, University of Toronto, Toronto, Ontario, Canada.

[2]Department of Psychiatry, University of British Columbia, Vancouver, BC, Canada.

REFERENCES

1. Latimer J, Lawrence A. The review board systems in Canada: an overview of results from the Mentally Disordered Accused Data Collection Study. Ottawa (ON): Department of Justice Canada; 2006.
2. Miladinovic Z, Lukassen J. Verdicts of not criminally responsible on account of mental disorder in adult criminal courts, 2005/2006–2011/2012. Ottawa (ON): Statistics Canada; 2014.
3. Crocker AG, Nicholls TL, Seto MC, et al. The National Trajectory Project of individuals found not criminally responsible on account of mental disorder in Canada. Part 2: the people behind the label. Can J Psychiatry 2015;60(3):106–116.
4. Crocker AG, Charette Y, Seto MC, et al. The National Trajectory Project of individuals found not criminally responsible on account of mental disorder in Canada. Part 3: trajectories and outcomes through the forensic system. Can J Psychiatry 2015;60(3):117–126.
5. Statistics Canada. Mental health-related disabilities in Canada, 2017. Ottawa (ON): 2019.
6. Bloom H, Schneider R. Mental disorder and the law: a primer for legal and mental health professionals. Toronto (ON): Irwin Law; 2017.
7. R v. Resler [2011] ABCA 167.
8. R v. Swain [1991] 1 SCR 933.
9. R v. Piette [2005] BCSC 1724.
10. Criminal Code, RSC 1985, c. C-46. [s.16[3]].
11. Winko v. British Columbia [1999] 2 SCR 625.
12. Criminal Code, RSC 1985, c. C-46. [s. 16[1]].
13. R v. Cooper [1980] 1 SCR 1149.
14. R v. Bouchard-Lebrun [2011] 3 SCR 575.
15. R v. Stone [1999] 2 SCR 290.
16. R v. Parks [1992] 2 SCR 871.
17. R v. Minassian [2021] ONSC 1258.
18. R v. Barnier [1980] 1 SCR 1124.
19. R v. Abbey [1982] SCR 24.
20. Kjelsden v. R [1981] 2 SCR 617.
21. R v. Chaulk [1990] 3 SCR 1303.
22. R v. Oommen [1994] 2 SCR 507.
23. R v. Ng [2006] ABCA.
24. Bradford JMW, Smith SM. Amnesia and homicide: the Padola case and a study of thirty cases. J Am Acad Psychiatry Law 1979;7(3):219–231.
25. Taylor PJ, Kopelman MD. Amnesia for criminal offences. Psychol Med 1984;14(3):581–588.
26. R v. J. -L.j. [2000] 2 SCR 600.
27. Arboleda-Flórez J. On automatism. Curr Opin Psychiatry 2002;15(6):569–576.
28. R v. Rabey [1980] 1 SCR 513.
29. R v. Daviault [1994] 3 SCR 63.
30. R v. Sullivan [2020] ONCA 333.
31. Glancy G, Patel K. R v. Sullivan: The Supreme Court of Canada takes a new look at automatism. J Am Acad Psychiatry Law 2021. Forthcoming.
32. R v. Ranieri [2015] ONCA 444.
33. Glancy G, Regehr C. Canadian landmark cases in forensic medical health. Toronto (ON): University of Toronto Press; 2020.