Updating Toxic Psychosis Into 21st-Century Canadian: *Bouchard-Lebrun v. R.*

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For centuries, Anglo-Saxon common law tradition has tended to limit voluntary intoxication as a defense on both mens rea (so-called diminished capacity defenses) and insanity. A new decision by the Supreme Court of Canada has clarified for Canadian jurisdictions whether voluntary substance-induced psychosis is a mental disorder for the purposes of determining insanity. In the United States, there is still considerable variation with regard to this question in such settled-insanity cases. This article is a review of Anglo-Saxon, American, and Canadian jurisprudence with regard to intoxication defenses on both *mens rea* and insanity. The factual and appellate history of *Bouchard-Lebrun v. R.* and a discussion of the Supreme Court's reasoning and the implications for future forensic practice follow. Potential pitfalls for forensic evaluators are explored, including the lack of scientific evidence available to detect individuals who, while appearing to present with a drug-induced psychosis, prove over time to have an endogenous psychotic illness.

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For centuries, Anglo-Saxon common law tradition has held that voluntary intoxication with drugs or alcohol may not be used to exonerate criminal behavior. Both in the United States and Canada, the common law tradition of limiting the application of intoxication defenses regarding the *mens rea* of an accused in so-called diminished-capacity defenses has been upheld. In addition, the insanity defense in the United States has historically been limited to those defendants who could show that their mental diseases or defects were settled (i.e., present only when no longer intoxicated, such as Korsakoff's syndrome). In Canada, there is a gap in the development of jurisprudence on settled-insanity cases, leaving courts and forensic evaluators without clear guidance as to how these cases should be resolved. This void has become more problematic, considering the burgeoning problem of ever more potent illegal intoxicants used by individuals at risk of serious mental illnesses. A recent decision by the Supreme Court of Canada on what constitutes a mental disorder, with regard to insanity provisions, has at least partially clarified the matter[1]; but there is still much debate, as we will see, in part because of the lack of clarity that our science can provide to clinicians and the courts. A summary of existing jurisprudence is provided in Table 1.

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Anglo-Saxon Jurisprudence

Until the 19th century, voluntary intoxication was viewed as an aggravating factor by the courts. However, in 1920 the British House of Lords in *Director of Public Prosecutions v. Beard*[2] stated the principle that intoxication could be raised as a *mens rea* defense with regard to offenses requiring specific intent. Thus, the notion of general and specific-intent offenses was created, leading to the possibility of the accused's receiving a reduced charge and sentence, but not an acquittal.

American Jurisprudence

While U.S. jurisdictions vary on whether they allow voluntary intoxication as a diminished capacity defense, they uniformly maintain a barrier to defendants wishing to plead their voluntary intoxication as a valid insanity defense when underlying evidence of pre-existing illness does not exist. In *State v. Bush*,[3] the court confirmed the principle that voluntary in-

Table 1 Summary of Existing Jurisprudence

United States	Voluntary intoxication may be used to defend against specific intent on *mens rea* in some states. Settled-insanity doctrine available in some states to distinguish from temporary insanity induced by voluntary intoxication. Evidence of mental disease or defect that surpasses insanity threshold independent of substance use should not be defeated, even if accused was intoxicated at the time.
Canada (before *Bouchard-Lebrun*)	Broad definition of mental disorder leading to insanity that excludes self-induced states caused by alcohol or drugs. Voluntary extreme intoxication available as a *mens rea* defense for nonviolent general-intent crimes. Voluntary advanced intoxication available as a *mens rea* defense for specific-intent crimes.

toxication with alcohol is not an excuse for crimes such as murder but may be used to defend against the specific-intent component of the case at court: deliberation and premeditation. In *Montana v. Egleho*ff, the U.S. Supreme Court upheld in 1996 a Montana statute that voluntary intoxication "may not be taken into account in determining the existence of a mental state which is an element of a [criminal] offense."[4] Since voluntary intoxication was an aggravating factor in 19th-century case law, a rule allowing it to be considered was "of too recent vintage, and has not reached sufficient uniform and permanent allegiance to qualify as fundamental, especially since it displaces a lengthy common-law tradition which remains supported by valid justifications today."[4] Many American jurisdictions will consider whether an accused had prior knowledge that he may have an excessive reaction to intoxicants (for example, an idiosyncratic reaction or delirium tremens). Juries may be informed that they need to consider the accused's prior awareness of his possible extreme reaction to substances in their deliberations.

Two recent cases uphold the notion of limiting the insanity defense only to those who can show that their claimed mental defect is settled or permanent. In *State v. Hartfield*,[5] it was held that the insanity defense could be pleaded when a defendant could show that his voluntary consumption of drugs or alcohol caused a permanent mental condition that destroyed his ability to distinguish right from wrong. In *Brunner v. State*,[6] the court held that an accused was entitled to a jury instruction that long-term drug use can induce insanity. Most states distinguish between settled and temporary insanity due to voluntary intoxication, the latter usually resulting in prevention of a claim of insanity from reaching the jury. However, the California Supreme Court held in *People v. Kelly*[7] that a defendant did not lose the right to plead insanity, regardless of whether the period of insanity lasted a few months or a few hours, even though she may have been high on drugs at the time of the offense. In *State v. Skinner*,[8] the California Supreme Court further outlined a four-criteria test for determining settled-insanity cases. Its ruling stated that the illness must be fixed and stable; last for a reasonable time; not be solely dependent on the ingestion of, or the duration of, the effects of the drug; and meet the jurisdiction's legal definition of insanity. Some states have statutorily rejected settled-insanity doctrine (Colorado, Connecticut, and Delaware).[9] In *United States v. Knott*,[10] the Ninth Circuit noted that the legislative history behind the Insanity Defense Reform Act of 1984 showed that Congress intended to exclude the insanity defense on the basis of voluntary intoxication alone. The appeals court stated in its decision that "[a] mental disease or defect must be beyond the control of the defendant if it is to vitiate his responsibility for the crime committed. . . . Insanity that is in any part due to a defendant's voluntary intoxication is not beyond his control."[9] However, *Knott* and a later 2nd Circuit decision, *United States v. Garcia*,[11] added that as long as the mental disease or defect was enough on its own to cause the lack of criminal responsibility, the coexistence of a voluntarily intoxicated state does not defeat the insanity plea.

Canadian Jurisprudence

Until *Bouchard-Lebrun v. R.*,[1] Canadian appellate courts have been relatively silent on substance-induced psychosis and insanity. Before this decision, the most representative case on the point was the landmark case that clarified the legal definition of a mental disorder, *Cooper v. The Queen.*[12] Temporary mental states self-induced by alcohol or drugs were explicitly excluded from the definition. Despite this, the Canadian Supreme Court has had a long history of maintaining a broad and inclusive definition of what constitutes a mental disorder as required for the

insanity provisions under Section 16 of the Criminal Code of Canada[13] (the criminal statutes that apply equally across all provinces and territories). However, there have been several important decisions by Canadian courts regarding voluntary intoxication and diminished capacity to which the Canadian Parliament has responded with legislated changes to the Criminal Code.

The *Beard* principles[2] regarding diminished-capacity defenses for specific-intent crimes have remained good law in Canada, with a few minor modifications. In 1978, the Supreme Court of Canada reaffirmed in *Leary v. The Queen*[14] that, when applied to general-intent crimes, a defense of voluntary intoxication could not be used to raise reasonable doubt concerning an accused's intent. After the adoption of the Canadian Charter of Rights and Freedoms in 1982, *R. v. Bernard*[15] widened the defense prospects of the accused by suggesting that extreme intoxication, causing a lack of awareness "akin to a state of insanity or automatism," could raise doubts as to the ability of an accused to form the required minimal intent for an offense, resulting in a not guilty verdict. In the 1994 decision *R. v. Daviault*,[16] the Canadian Supreme Court confirmed and extended this principle to general-intent crimes such as sexual assault, even when the intoxication was voluntary. The Court explained that "[a] person intending to drink cannot be said to be intending to commit a sexual assault." Following significant public and political outcry as a result of this decision, the Canadian parliament legislated changes to the Criminal Code one year later, reversing the ban on voluntary intoxication pleas on *mens rea*. Since the implementation of Section 33.1 of the Criminal Code,[17] the only voluntary-intoxication pleas permitted on the question of general intent are for those crimes that do not interfere with the bodily integrity of the person. The Canadian Supreme Court went on in 2007 to interpret Section 33.1 of the Criminal Code in *R. v. Daley*[18] and reaffirmed the wish of the legislature while reiterating that voluntary intoxication is still available as a defense to diminish responsibility for specific-intent crimes. The justices also laid out the three intoxication states recognized by the courts: light, advanced (the most commonly encountered and available for diminished capacity pleas), and extreme (akin to automatism). Only extreme intoxication could be used to plead an inability to form the requisite *mens rea* in nonviolent general-intent crimes. Idiosyncratic reactions to a voluntarily taken substance also fit the latter category.

Case History: *Bouchard-Lebrun v. R.*

Tommy Bouchard-Lebrun and a long-time acquaintance smoked marijuana and took amphetamines on October 23, 2005. That evening, while still intoxicated, they took a bus to visit Mr. Bouchard-Lebrun's parents. When they arrived a few hours later, they then hitchhiked to another town. They were picked up early in the morning of October 24, 2005, by an acquaintance of his family. Once dropped off in the town of Amqui, Quebec, the two young men took some ecstasy pills, known as *poires bleues* (blue pears). During the hours that followed, still early in the morning of October 24, 2005, the two decided to beat up Dany Lesveque, for the real or imagined reason that he wore a necklace with an upside-down cross.

After entering the apartment building of Mr. Levesque illegally around 5 a.m., Mr. Bouchard-Lebrun began to assault Mr. Levesque. Witnessing the inability of Mr. Levesque to defend himself against the brutal attack of the two young men, a neighbor, Mr. Dumas, tried to intervene. Mr. Bouchard-Lebrun grabbed Mr. Dumas, threw him down the stairs, and went down the stairs after him; there, he stomped on his head, causing permanent cognitive disability requiring long-term hospital care. Mr. Bouchard-Lebrun's psychotic symptoms disappeared several days after the assault.

During the trial, Mr. Bouchard-Lebrun pleaded that he had a shared psychotic disorder due to the negative influence of his accomplice. Although the acquaintance of Mr. Bouchard-Lebrun's family who had picked the two young men up early in the morning of October 24, 2005 told the court that Mr. Bouchard-Lebrun did not appear intoxicated at the time, implying that the effects of the drugs taken the day before had cleared, it was never in dispute during any of the proceedings that Mr. Bouchard-Lebrun was in a severe psychotic condition during the attack on Mr. Dumas. Several witnesses attested to his bizarre behavior and speech during and immediately following the assault. The prosecution produced its own expert who opined that he had a drug-induced psychosis due to his voluntary consumption of the blue pear pills. In addition, it was adduced at trial that the accused had never experienced a separate psychotic episode induced by substances or other-

wise, either before or after the crime. Both psychiatric experts at trial agreed that Mr. Bouchard-Lebrun had "a severe psychosis that made him incapable of distinguishing right from wrong."[1] Section 16 of the Criminal Code of Canada states the following standard that must be applied for an insanity defense to succeed: "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 (in the moral sense)."[13]

The judge accepted the prosecution's view regarding the toxic cause of psychosis, and Mr. Bouchard-Lebrun was found guilty of aggravated assault and sentenced to five years in a federal penitentiary. The judge also acquitted him of the general-intent crime of breaking and entering (an offense that has no impact on the bodily integrity of the person) because his extreme intoxication was akin to an automatistic state.

Mr. Bouchard-Lebrun appealed his conviction to the Quebec Court of Appeal. He no longer contested that he had been in a psychotic state brought on by his voluntary intoxication from illegal drugs. He argued that the insanity defense should have been applicable because of the evidence at trial that he had been unable to distinguish right from wrong at the material time and that his toxic psychosis should have been considered a mental disorder according to the meaning set forth by Section 16 of the Criminal Code of Canada. In a general sense, he argued that the judge had confused the insanity defense under Section 16 with the defense of voluntary intoxication under Section 33.1 of the Criminal Code of Canada.

The appeal court justices unanimously rejected the appellant's arguments and acknowledged that the courts had held that the insanity defense was available to an accused with an underlying mental disorder, whose mental condition had deteriorated even more as a result of drug use. However, the justices held that the Canadian Supreme Court had clearly ruled in *Cooper*[12] that temporary psychosis induced by drug use cannot be considered a disease of the mind within the meaning of Section 16.

The Supreme Court of Canada's Analysis of *Bouchard-Lebrun v. R.*

The Supreme Court justices began hearings on the matter in May 2011. The central questions on appeal were: does Section 33.1 of the Criminal Code limit the scope of the defense of not criminally responsible on account of mental disorder provided for in Section 16? Can a toxic psychosis with symptoms caused by a state of self-induced intoxication be a mental disorder within the meaning of Section 16? The principal arguments of the appellant were the following: all, even voluntary, drug-induced psychoses should be considered a mental disorder under Section 16, because only people with a particularly fragile or vulnerable psyche would develop a drug-induced psychosis; the origins of a toxic psychosis must therefore be in a preexisting mental state of the accused.

The Supreme Court of Canada rendered a unanimous decision signed by all nine justices, rejecting Mr. Bouchard-Lebrun's appeal on November 30, 2011. In reaching the judgment, a previous landmark case involving the automatism defense, *R. v. Stone*,[19] was applied. Two other cases discussed were *Daviault*[16]and *Cooper*,[12] the latter being the ruling that delineates the definition of mental disorder in Canada. Analyses of *Daviault* and *Stone* have been explored in previous articles in *The Journal*.[20,21]

In his analysis of *Bouchard-Lebrun*, Justice LeBel stated for the majority that insanity and intoxication are two distinct legal concepts, and therefore, Section 33.1 of the Criminal Code should not be interpreted, so as to limit the scope of Section 16. The justices reiterated that in *Cooper*, Justice Dickson had written for the majority that a mental disorder ". . . 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."[12] The Court agreed with legal scholars[22] that, "the inclusive nature of the definition of mental disorder can be explained in particular by Parliament's wish to give the public a high level of protection from persons who could be a threat to others."[1] The Supreme Court reminded us that the qualification of mental disorder is an ultimate issue to be resolved only by the judge. Once the judge rules that a condition meets the legal definition of mental disorder, he can then instruct the jury that its members must decide whether the individual, in fact, had the mental condition at the material time. The role of psychiatric experts is to inform the court about the mental state of the accused at the time of the act or omission, from a medical point of view. The Supreme Court also expanded on the limits of the role

of experts and the value of their opinions regarding mental disorder. Justice LeBel cited two cases that illustrate the suspicion that Canadian appellate courts appear to hold concerning the opinions of psychiatrists, a suspicion that reflects somewhat the climate in American courts where such a perception has existed for some time and in particular, following the adoption of the *Durham* rule on insanity in Washington D.C.[23] The outcomes of the two cases referred to by Justice LeBel are as follows.

In *R. v. Parks*,[24] the Supreme Court of Canada stated that "the trial judge is not bound by the medical evidence, since medical experts generally take no account of the policy component of the analysis required by Section 16 of the Criminal Code of Canada." In addition, in *R. v. Luedecke*,[25] the Ontario Court of Appeal stated that "an expert's opinion on the legal issue of whether the mental condition of the accused constitutes a 'mental disorder' within the meaning of the Criminal Code has little or no evidentiary value."

Justice LeBel concluded: "If the appellant's position were accepted, psychiatric experts would thus be responsible for determining the scope of the defense of not criminally responsible on account of mental disorder."[1]

The Supreme Court justices underlined that analysis of the availability of a Section 16 defense in the context of a drug-induced psychosis must be done on a case-by-case basis. This is because ". . . medical science does not always identify the causes of toxic psychosis as precisely as is required in law."[1] They reiterated their position in *Rabey v. The Queen*,[26] stating that this analysis is necessary because of the difficulty in categorizing transient states with regard to whether they are in fact a mental disorder. The starting point for a judge in analyzing a case where the accused was psychotic and still intoxicated must be the general principle that temporary psychosis be excluded, according to *Cooper*.[12] However, this exclusion is not absolute, because the accused may rebut with evidence of a mental disorder at the material time, in addition to the intoxicated state.

Justice LeBel described an innovative approach to assessing the central issue in law, borrowing from the "more holistic approach" promulgated by Justice Bastarache for analyzing automatism defenses in *Stone*.[19] This flexible method uses two analytical tools and certain policy considerations. First, using the internal-cause factor, one compares the accused with a normal person. The more that psychiatric evidence shows that a person free of mental illness would have developed similar symptoms under similar circumstances, the more the courts should consider the trigger to be external. Second, using the continuing-danger factor, a condition should be regarded as a disease of the mind when it is shown to present a recurring danger. The court should consider the psychiatric history of the accused and the likelihood that a trigger of the episode would recur in adducing such a conclusion. Third, courts should heed certain policy considerations, such as ". . . the need to protect society from the accused through the special procedure set out in Part XX.1 (the Mental Disorder portion) of the Criminal Code of Canada."[1] If the preexisting condition of an accused does not require any particular treatment but presents a risk to public safety, then courts should more easily find that the individual had no mental disorder at the time of the act or omission. However, Justice LeBel was careful to point out that the recurrence-of-danger factor is not linked to voluntary behavior by the accused. He appeared to anticipate pleas by those who would claim to have drug dependency when he added:

> The purpose of the defense of "mental disorder" is to ascertain whether the mental condition of the accused poses an inherent danger, that is, a danger that persists despite the will of the accused. As a corollary to this principle, a danger to public safety that might be voluntarily created by the accused in the future by consuming drugs would not be the result of a "mental disorder" for the purposes of section 16 of the Criminal Code of Canada.[1]

He concluded by stating that Section 16 defenses are intended to exempt individuals from responsibility when their actions are "morally involuntary."

Application of Principles to *Bouchard-Lebrun*

The Supreme Court justices rejected Mr. Bouchard-Lebrun's appeal by applying the holistic approach, which supported the view that his psychosis appeared to have been caused by an external factor, the blue pear pills. Evidence from the prosecution expert at trial that a significant number of normal individuals have psychosis after using PCP and amphetamines supported this probability. According to evidence before the Court, Mr. Bouchard-Lebrun did not appear to present a continuing danger to public safety as long as he abstained from using drugs. They rejected his, some lower courts', and

legal scholar's theories that substance-induced psychoses are always a mental disorder with regard to Section 16 of the Criminal Code.[27–31] The Supreme Court agreed with his acquittal on the charge of breaking and entering, because Section 33.1 does not limit the level of intoxication in its application, and hence a toxic psychosis can be used to vitiate responsibility for non-personal injury offenses, such as the one at court.

Discussion

This case is important for numerous reasons, especially when considering the unanimous nature of the ruling. It is a reminder for forensic practitioners of the Supreme Court's desire to maintain the judicial gatekeeper role and limit psychiatric pronouncements on ultimate issues. In Canada, the courts seem to be telling us that in addition to insanity, the mental disorder criteria of the noncriminally responsible statute is another such ultimate issue. However, forensic experts are still vital to the courts' understanding of criminal responsibility and should render opinions about the presence of a mental state or illness. They are essential to help the court understand the possibility of a causal nexus to the latter criteria of the legal test. In particular, experts are still permitted to render opinions directly on the nature, quality, and wrongfulness criteria.

There is some similarity between the approaches taken by the Supreme Courts of Canada and the United States in the legal definition of mental disorders, albeit in different arenas. In *Cooper*,[12] the Supreme Court of Canada elected to adopt an inclusive stance in criminal settings because of the legislators' desire to protect the public from dangerous persons. In the civil commitment setting of *Kansas v. Hendricks*,[32] the majority of the United States Supreme Court Justices (including three of the four dissenters) similarly upheld the broad definition of mental abnormality put forth by the Kansas legislature in their Sexually Violent Predator Act, as satisfying substantive due process. They reiterated the quote from *Ake v. Oklahoma*[33] that "psychiatrists disagree widely and frequently on what constitutes mental illness," and noted that courts have used a variety of expressions to describe the mental health concepts in civil and criminal judicial settings (for example, insanity, incompetency, emotionally disturbed, and mentally ill). They quoted themselves from *Jones v. United States,*[34] where a legislature "undertakes to act in areas fraught with medical and scientific uncertainties, legislative options must be especially broad and courts should be cautious not to rewrite legislation." The United States Supreme Court also noted in *Hendricks* that the Kansas scheme was constitutional because the definition of "mental abnormality" had to be linked to a predictable risk of dangerousness.

The decision in *Bouchard-Lebrun* has laid out a clearer judicial approach to parsing the availability of the insanity defense in Canada where the line between intoxication and long-term endogenous illness may be murky. The Supreme Court of Canada clearly recognized the limits of medical evidence on the questions of the exact cause of psychosis in contexts where intoxicants have been consumed.

It has long been evident among clinicians that it can be very difficult to distinguish between substance intoxication and substance-induced or endogenous psychotic states. There continues to be debate and effort to refine the diagnostic methods and criteria to reflect better the clinical reality.[35] Currently, DSM-IV-TR classification allows for three possible diagnostic entities when substance use is identified as the etiologic agent and there is a presence of psychotic symptoms: substance intoxication, substance-induced delirium, and substance-induced psychosis. These may appear to be on a continuum, but were not created as such. Some have argued in *The Journal*, that the current nosology in DSM-IV-TR adds to confusion, especially in forensic contexts involving insanity provisions, because the diagnostic criteria force the dichotomous choice of assigning causation to either the exogenous substance or an independent mental disorder.[35,36] The demarcation between substance-induced psychosis and an endogenous psychotic disorder may not be as clear as the legal process would often like, given the current state of our knowledge and science.

The psychiatric community is well aware of the dangers of illicit drugs, not only for patients with a known mental illness, but for those with healthy minds, as well. A significant number of occasional and habitual users of methamphetamines or cocaine, for example, report psychotic symptoms.[37] Evidence that would help distinguish between individuals with a drug-induced psychosis who will or will not develop a long-term psychotic illness is lacking. It is, of course, extremely difficult to study such populations, in part because illicit drug users rarely take only one drug and often do not know in fact what they are

taking. The quantity and number of drugs ingested and the differences in rate of storage and release of illicit drugs from fatty tissues may have a great impact on the expected duration of psychosis. A review of studies of stimulant-induced psychoses noted that 1 to 15 percent of patients continued to have psychotic symptoms beyond one month.[38] Examination of an accepted method developed for establishing psychiatric diagnosis, by Robins and Guze,[39] shows that we have few solid clinical tools as of yet to clarify the conundrum. There are not yet any clinical description, features deriving from other illnesses, or follow-up and familial studies to assist in this process. To date, no reliable laboratory, imaging, or psychological test confirms the presence or absence of a schizophreniform disorder. Specific symptom patterns of different drug-induced psychoses do not discriminate across subtypes of schizophrenia as of yet.[40] Many studies conducted in Japan have suggested that persistent methamphetamine psychosis is an entity, and the duration of psychotic symptoms is measured by such researchers in months, even years, after drug use has ceased.[41] This point of view is controversial and not widely accepted by Western clinicians, in part because similar risk factors present between the two (for example, personality traits and familial loading). However, the current criteria for a substance-induced psychotic disorder in DSM-IV-TR suggests arbitrarily and without empirical support, a one-month period of abstinence before considering that drugs are not the causal factor.[36] In family and genetic research, evidence that could help distinguish primary and substance-induced psychosis is equivocal. Some research has suggested that genes encoding glutamate and NMDA receptor functioning thought to represent susceptibility loci in schizophrenia contribute to methamphetamine psychosis as well.[41] Danish studies have shown that people with cannabis-induced psychosis have the same familial predisposition as schizophrenics have.[42] In one such study of over 2 million individuals, approximately one half of those with cannabis-induced psychosis met criteria for schizophrenia nine years later.[40] The Supreme Court of Canada rightly captured the limits to the state of the evidence as it currently stands in this arena.

Bouchard-Lebrun puts forth a logical analysis to be undertaken by Canadian courts in insanity contexts, but significant uncertainty and questions regarding long-term outcomes of these individuals remain. For example, an accused might offer a plea of insanity without any evidence of psychiatric care after the offense and during their pretrail detention. This scenario is especially possible for individuals evaluated while in jails that have little psychiatric infrastructure. They are likely to be lost to follow-up, especially if their symptoms, marked by negative symptoms and lack of insight, resume a milder course in the absence of drugs. It is entirely possible that such individuals, for whom a substance-induced psychosis is in fact the first presentation of a chronic psychotic illness, may miss the opportunity to avail themselves of an insanity verdict.

It is clear in *Bouchard-Lebrun* that the Supreme Court justices have tried to support the legislators' apparent emphases in the Criminal Code on protecting society from dangerous persons and preventing frivolous insanity claims that would diminish the public's faith in the judicial process. It appears that in borderline cases, evidence of dangerousness has crept into the analysis of what constitutes a mental disorder that may lead to insanity. Although the high court clearly wants to maintain the judicial role as final arbiter of what is a disease of the mind, evaluating forensic clinicians will continue to be solicited to provide the expert knowledge essential to this analysis.

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