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MENTAL DISORDER IN THE CRIMINAL JUSTICE SYSTEM

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Ministry of the Solicitor General of Canada

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EXECUTIVE SUMMARY

Part Two

A fundamental review of criminal law in "an evolving Canada" and a "changing world" is underway (Canada, 1982). One portion of this review focuses on mental disorder in the criminal justice system. Following a general introduction and overview, Part Two presents a comprehensive schematic overview of the mentally disordered offender and how he is processed in Canada. The objectives of this section are to assist in a comprehensive identification of the issues and put each component in its criminal justice and mental health context. The exercise should also facilitate the resolution of definitional criteria, disposition, and jurisdiction issues along the path of criminal, civil, and correctional processing.

Any such analysis, however, must incorporate a thorough review of the social context if it is to be contemporary and relevant. Too often, these background factors are not adequately addressed. For example, public sentiment, mental health certificiation, jurisdiction and costs, accommodation and treatment, client consent, and dangerousness constitute just some of the important but problematic social issues with which an effective system must contend.

A pivital component of any such exercise is the provision of legal definitions with good operational criteria and appropriate

terminology that are in the spirit of the underlying fundamentals. Therefore, a logical sequence is to begin by reviewing the fundamental principles of our mental disorder legislation. With terms defined in a manner consistent with these fundamentals, the basis "building blocks" are established, and the remainder of the exercise becomes somewhat simplified. Only by undertaking a complete analysis at this stage can one expect the subsequent legislative, policy, and treatment components of remand, fitness, and insanity to assume their place in a logical and systematic manner.

Once these legislative issues are resolved, the problems of disposition, jurisdiction, treatment, and identification of other mental disorders can be addressed in a rational and effective manner. This kind of sequence will contribute to our knowledge as to what type of offender, as defined legally and psychiatrically, requires or is best suited to, what kind of disposition (management or treatment) and by what jurisdiction (legal, mental health, or corrections) this ought to be accomplished.

This process analysis leads to the following observations and projections. A community perspective will produce greater accomplishments in the prevention of mentally disordered crime and in the use of mental health diversion. Psychopaths and other mentally disordered offenders, who are neither certifiable nor "insane", will continue to populate our prisons. Current mental health and correctional systems are either unequipped or incapable of accommodating and treating them. Mental health postrelease programs

are inadequate. Client volition and treatment ineffectiveness continue to be major problems. Prediction difficulties notwithstanding, the assessment of dangerouness will continue to be a major factor in most processing decisions of the mentally disordered offender.

Part Three

Despite the fact that most studies dealing with the criminalization of the mentally disordered are fraught with methodlogical errors, the evidence tends to support the criminalization hypothesis: the mentally disordered are being caught up in the criminal justice system. This is occurring because of the deinstitutionalization with mentally ill, the police practices in handling the mentally ill, and the inaccessibility to treatment on the part of many disordered individuals who are at risk for criminal offences. The streaming of the mentally ill into the criminal justice system has been documented in the single methodologically sound study (Teplin, 1984) done to date. Considering that correctional facilities are not typically designed for a psychiatric clientele, it stands to reason that there will be a burgeoning number of untreated psychiatric clients if de- and noninstitutionalization continues (Allodi, Kedward & Robertson, 1977).

The fact that the criminalization of the insane is taking place can be considered a comment on the failure of the community health movement. In reality, ill-prepared dischargees were left to fend

for themselves, and eventually became the wards of an alternate service system (Whitmer, 1980). However, another perspective is to simply view the criminalization phenomenon as a reflection of changes in the relative use of two methods for dealing with the socially aberrant (Biles & Mulligan, 1973). In the end, society finances both systems, and it may even be less expensive to detain persons in jail. However, to the extent that society subscribes to a rehabilitative model, the mentally ill must be accommodated in facilities commensurate with their need for care. The principle of universal access to health care must be maintained even for incarcerated offenders.

Part Four

The mentally disordered sentenced offender has been largely ignored in the mental health and legal literature in spite of his prevalance and the problems he creates in the inmate population. The group has been overlooked partly because of the preoccupation with the forensic issues of fitness and insanity and because, at least theoretically, serious cases should be filtered out of the correctional system by legal proceedings. The best estimates suggest rates of 5% and 15-20% for serious and less serious forms of mental illness, respectively (Monahan & Steadman, 1983). For a variety of reasons, few cases are referred to provincial mental health facilities.

Less severe forms of mental disorder include some particularly troublesome types of offender. For example, the psychopath may be very difficult to mange or treat and is quite prevalent in prison. The most cautious surveys indicate rates of 20% (Wong, 1984) and 30% (Hare, 1980) in Canadian penitentiaries.

One model that has been reported to be very successful, at least subjectively, is the State of Washington's treatment of sexual offenders. Although sexual offenders are not necessarily mentally disordered, they do present similar management and treatment problems. Therefore, Washington's "Sexual Psychopath" legislation provides an interesting model as to how the court, mental health system, offender, and community can all be involved in a systematic, long-term treatment program that maintains continuity over the duration (Brecher, 1978; Borzecki and Wormith 1984).

Finally, one must acknowledge the difficulty in treating the mentally disordered incarcerated offender. Most are not, nor could they be, certified under provincial mental health legislation which means that treatment must be voluntary. Aside from those who outrightly decline participation, others, although superficially cooperative, are resistent to treatment efforts, the effectiveness of which remains at issue in correctional and mental health circles.

PART ONE

INTRODUCTION AND OVERVIEW

Definition

To begin, one must point out that the "mentally disordered offender" is an umbrella term that cuts across various legal and mental health categories (Hartstone, Steadman, Robbins and Monahan, 1984). In the broadest sense, it includes defendents who are found unfit to stand trial or not guilty by reason of insanity (NGRI), convicted prisoners who are transferred to mental hospitals, and some special offender groups as defined legally by certain jurisdictions. These four types of mentally disordered offenders and their various legal definitions are nicely presented in tabular form by Favole (1983) who reviewed the relevant statutes in 50 U.S. states. Finally one must not overlook convicted offenders who are not removed from prison, either for adminstrative reasons or because their disorder is less serious and does not qualify one for any of the other conditions. In psychiatric terms, mental disorders can be limited strictly to the serious, psychotic disorders or it can include the diagnostic categories of neurosis, personality disorder, and psychosexual disorders.

Background

The interface between mental disorder and the law has existed

for hundreds of years. Recognition of the insanity defense by the common law can be traced back as far as the fourteenth century (Holdsworth, 1926). It has been a problematic area to legal and mental health officials at least since the MiNaughten case (1843) when the court decision produced a strong public outcry. In Canada, practical implications began as early as 1852, when a criminal lunatic asylum was built in Ontario for the specific purpose of housing lunatic convicts separate from the general inmate population and to improve the conditions at the penitentiary (Chalke, 1973).

Today, the relationship between the mental health and legal systems implicates many issues from diverse areas. It involves basic questions of law, medicine, social science, and ethics. The area is fraught with dilemmas as mental health services must content with public safety, while government policy makers must be cognizant of what is administratively possible, and legislators must consider what is practically feasible.

Although concern for the mentally disordered offender and their lack of facilities can be traced from early wardens of the Kingston penitentiary at the turn of the century (Chalke, 1964, 1973), through various commissions including the Archambault Report, (1938), Fauteux Report, (1956), and a Royal Commission on Sexual Psychopaths, (1958), to a recent Ten Year Plan (1963), the Ouimet Report (1969), and Solicitor General's Annual Report in 1970 (see Chalke, 1973; Weisstub, 1980), it has only been during the last decade that the mentally disordered offender has received the atten-

tion he needs and deserves in the scientific and professional literature. The Law Reform Commission of Canada published the results of its investigation in its Report to Parliament on Mental Disorder in the Criminal Process in 1977. Other recent Canadian publications include books by Schiffer (1978), Hucker, Webster and Ben-Aron (1981) and Weisstub (1980; 1984). Shah (1981) notes that the growing interest and attention received by forensic mental health is illustrated by at least eight journals that began their publication in the last 15 years. Although attention has been paid to the interface (Beran & Toomey, 1979), a recent edition by Teplin (1984) entitled Mental Health and Criminal Justice represents a major contribution as the first serious look devoted to dynamics of intersystem processing. Finally, as part of a fundamental review of our criminal law (Canada, 1982), a detailed legislative analysis of mental disorder in Canadian law has been undertaken by the Department of Justice (1983).

Outline

This paper sets out to review three aspects of the mentally disordered offender that are crucial to our conceptualization, understanding, and treatment of this group. First, it provides a general overview of the mental health-criminal justice interface. As a process description, this section addresses issues of definition, client flow, and decision points between these vast and complex systems. Secondly, the paper reviews a specific phenomenon,

the criminalization of the mentally ill. In this section, a literature review leads one to conclude that the mentally disordered offender will continue to grow numerically and as a burgeoning issue to criminal justice practitioners and policy makers. Studies indicate that there are at least three reasons for this criminalization phenomenon: deinstitutionalization of the mentally ill, police handling of the mentally ill and inaccessibility to treatment for certain types of mental disorder. Because these trends are revealed in Part Three, the paper then considers various issues pertaining to the mentally disordered sentenced offender. Although this group includes a small, but highly visible sample of psychotics, perhaps 5% of the inmate population, it is comprised primarily of personality disorders including many psychopaths and sexual offenders. Therefore, the paper concludes with a review of certain legislative, policy, and treatment issues that are raised by these 'special' offenders.

PART TWO

PROCESSING THE MENTALLY DISORDERED OFFENDER

Background

Criminal and civil processing of the mentally disordered offender is a complex operation, guided by diverse legislation and effected by even more diverse social service systems. At one point or another, the Criminal Code, ten provincial Mental Health Acts, the Penitentiary Act, the Parole Act, the Young Offenders Act may all be invoked. Although the focus of official offender processing typically falls in the legal arena, such processing must also relate to the mental health and correctional operations responsible for implementation and to the realities of these systems. Furthermore, criminal justice processing is not limited to a single decision per case for each offender. Instead, it is a dynamic process, consisting of many events and lasting, in some cases, over many years.

Each stage of mental disorder criminal processing must rely on an essential premise. Some of these have been presented by the Law Reform of Canada (LRC). For example, the fitness rule promotes "fairness to the accused by protecting his rights to defend himself and by ensuring that he is an appropriate subject for criminal proceedings" (LRC, 1977). The insanity defense rests on the "fundamental moral view that insane persons are not responsible for

their actions and are not therefore fit subjects for punishment" (LRC, 1982). Principles for remanded and convicted mentally ill offenders still require precise enunciation.

A thorough analysis of these complex systems can only facilitate the identification and clarification of issues and problem areas by positioning them in their social and legal context. To this end, an initial path description of the mentally abnormal offender was developed by Allodi, Kedward and Robertson (1977). The following schematic overview is offered as a detailed, but skeleton outline of the linkage between our legal, mental health, and correctional systems. The scheme is also presented diagrammatically in Figure 1 to illustrate the processing complexities between these systems. Some of the critical issues are identified in the context of this review and are submitted to a later section of the paper for elaboration and discussion.

Community

A thorough analysis of criminal justice processing of the mentally disordered offender must begin with a review of the social and community context. The following comments outline some of the descriptive elements of the environment from which mentally disordered offenders emerge.

National statistics indicate that 10% to 30% of the Canadian population, depending on definition, have some form of mental ill-

ness (Statistics Canada, 1981). It is projected that 12.5% of our population will be hospitalized for a mental illness at least once during their lives. Certainly, there is no reason to believe that the incidence of mental disorder among current and potential offenders is any less than that of the population at large.

The Community Mental Health movement has flourished through the 1970's and open door policies have led to lessened security in mental health facilities. Meanwhile deinstitutionalization policies and pharmacological breakthroughs have led to the release of many psychiatric patients to the community. Normalization theory (Wolfensberger, 1972) has been widely accepted as an operating principle in the field of mental retardation and has led to the development of community programs and facilities for the developmentally handicapped. Although the number of psychiatric admissions between 1968 and 1978 increased by 25%, this should not detract from the fact that there were 200,000 psychiatric discharges across the country in 1978, 72% of whom were from general hospitals (Statistics Canada, 1981). Now in the 1980's, there is a growing sentiment that deinstitutionalization, if not a failure, was effected poorly and prematurely (Lamb, 1981) as it lacked an appreciation for the socio-cultural context in which it was initiated (Estroff, 1981). This is evidenced by prison surveys of mental disorder rates during times of mental health policy change. For example, a Correctional Service of Canada (CSC) survey revealed that the percentage of mentally retarded inmates in one federal penitentiary increased almost four fold between 1969 and 1977 (Wormith, 1979).

It follows that one must expect mental disorder to be a sizeable problem among law violators in the community. Although early studies suggested former mental patients to be less often arrested than the general population (Brill and Malzberg, 1954), it is now clear from recent studies that former patients are arrested more frequently than the general population. For example, Cocozza, Melick and Steadman (1978) and Steadman (1981) cite a rate of 2.7 to 3 times greater than the general population. It is noted, however, that the subset of former patients having no history of previous offence are less likely to be arrested than the general population. Nonetheless, even a conservative estimate would suggest that the incidence of mental illness among offenders is at least that (12.5%) of the general population (Guze, Goodwin, and Crane, 1969). Based on demographic knowledge, one could easily assert that the rate must be somewhat higher. Given the long standing relationships that both crime (McGarvey, Gabrielli, Bentler and Mednick, 1981; Braithwaite, 1981) and mental health (Hollingshead and Redlick, 1958; Riessman, Cohen and Pearl, 1964) have shared with low socio-economic status, one would only expect the offender population to be a risk for mental disorder.

The literature on public attitudes towards mental illness (Steadman, 1981) indicates there is a general agreement that the mentally ill are seen as dangerous and unpredictable (Nunnally, 1961; Olmsted and Durham, 1976). Public resistance to the community placement of ex-mental patients has become increasingly organized. Yet the "criminally insane" are considered far more dangerous and

unpredictable and are feared far more than the "traditional" mentally ill patient. This popular perception has been formulated largely on the mistaken impression as to who is included in the "criminally insane" (Steadman and Cocozza, 1978). The authors cite biased and inaccurate press coverage as being responsible. Clearly, legislative, policy, and operational bodies must be cognizant of these background facts.

A review of mental health and crime in a community context raises many more issues. Three of the most critical questions are cited below.

1. How can legislation and the mental health community decrease the likelihood of criminal behaviour, particularly violent criminal behaviour by mentally disordered individuals? Specificially, can provincial Mental Health Acts be used more effectively to identify and if necessary incapacitate those who are "dangerous to themselves or others" and at the same time protect individual rights in accordance with our Charter of Rights and Freedoms (Canada, 1982)?

2. Can or should the mental health system provide a diversion route post-apprehension, but prior to charge, as is often done in the referral of alcohol cases to detoxifications centres. Many police agencies have expressed great interest in the mentally disordered suspect (Canadian Association of Chief of Police and Federal Correction Service, 1981). Given what is known about incarceration, prison treatment, and recidivism, mental health diversion is equally

appropriate for many psychiatric cases as diversion to the detoxification centre is for certain alcoholics. However, as pointed out by Stevens and Roesch (1980), there may be difficulties with police screening of the mentally ill. If discretion is left to individual officers, differential processing may ensue. Such an effect has been observed both by race (Banks, 1977) and social class (Brakel, 1971). The issue of screening mentally disordered offenders is brought to our further attention by a recent American study in which 4½% of the admissions to a large metropolitan jail were referred for psychiatric examination. Virtually all of these referals were psychotic and more than three quarters could have been hospitalized involuntarily according to the state criteria (Lamb and Grant, 1982).

3. These issues raise additional questions of containment and release. Logic dictates that at this point the responsibility should fall in the realm of mental health officials. If an individual meets the criteria of an involuntary admission, the mechanism for release is automatically in place. The release criteria should not vary with the source of identification of any particular patient. It makes no theoretical difference if one is apprehended for shop lifting and deferred to mental health facilities via a mental health act or simply referred by one's family for idiosyncratic behaviour. The length of hospitalization may be independent of the behaviour that brings one to social attention. The consequence is that an individual may be

institutionalized for a lengthy period, seemingly for a minor offence.

Regardless, if civil commitment and voluntary mental health programs are to be considered as preventive or diversionary options to the criminal justice system, it is evident that greater resources must be directed to this end. Secondly, the broad implications of deinstituionalization must be reviewed in their social context. In addition, this kind of program development would and should generate greater demands for safeguards on the committal and review procedures.

Bail

The provision of bail for the mentally disordered accused was addressed by the LRC (1977). The Commission proposed various recommendations depending on whether the disorder is related to the offense charged. "If the accused's psychiatric state is directly related to his crime, pre-trial detention criteria under the criminal law would be appropriate." On the other hand, the LRC also claims that no mentally disordered accused should be refused bail if his disorder is unrelated to the offense charged. This position is unnecessarily confusing in that two systems of detention are confounded. Either, one is detained under the usual bail criteria in accordance with the traditionally accepted principles of bail, which may be affected by mental status or one is a candidate for civil commitment. In the latter case, where one has been brought to

judicial attention only as a chance result of one's apprehension and criminal charge, the judiciary is, nonetheless, honour bound to bring the case to the attention of civil authorities for examination. Therefore, it is possible, but unlikely, that one may qualified for bail but not pass a civil commitment examination. Hence, a civil commitment might ensue in accordance with its traditional criteria and means of review.

In addition, one may not qualify for bail and also be certifiable. In this case, issues of accommodation, responsibility, and jurisdiction are raised. Clearly, the individual will be detained, but questions of where and how must be resolved. Although the sequential order of events might suggest the bail decision and resulting remand custody take precedent, a mental health precidence would result in a temporary pre-trial diversion from criminal justice holding facilities, be more humanitarian, and facilitate subsequent legal processing. In sum, the issue of bail and mental health are related only in as much as one's mental condition might affect an accused's capacity to be granted bail under the standard criteria.

Fitness

The issues and decisions of bail approximate, but are not identical to, nor should they be confused with, the issues of fitness. Indeed, it is theoretically possible for an accused to meet bail criteria and not be certified, yet be found unfit. This comes

as no surprise since the underlying rationale and principles of the three conditions are quite different.

As the LRC has suggested, the purpose of a fitness rationale is to promote fairness to the accused by protecting his right to defend himself and by ensuring that he is an appropriate subject for criminal proceedings. The fitness question raises four principle issues; criteria, procedures, jurisdiction, and review.

The fitness principle is founded on a concept that is independent of mental health. Indeed, developmental retardation, communication disorders, and even age may render one incapable of defending oneself. To this end, criteria need to be operationalized in the Criminal Code to provide for the reliable assessment of a group of conditions that are not necessarily circumscribed by mental illness. In this context, "capacity" may provide a more accurate description in that, unlike "fitness" or "competence" to stand trial, it connotes reasons beyond the realm of mental health. Regardless of the nomenclature, considerable work has been done to develop and promote the implementation of an objective interview-based fitness assessment to be used by forensic specialists (Roesch, 1978a; 1978b).

As observed by the Alberta Special Interest Group on the Mentally Disordered Offender (1982), one might be declared lacking capacity (unfit), yet not meet civil commitment criteria. Or alternatively, be cerified for a short period during a lengthy

unfitness detention. Since lack of fitness carries with it an indefinite detention and a strict review process, defense counsels, at least in some provinces, tend to raise the issue only if conviction is inevitable and the charge, severe. However, should not the fitness defense be equally available to all who are accused? Procedural innovation is suggested to rectify, at least in part, this dilemma. By delaying the request for fitness examination until the outcome is virtually known, the defence counsel is not "risking" an indetermined detention of his client when an acquittal might be possible. Secondly, one may garner evidence as to fitness in the course of the offender's hearing, although such a practice runs the very real risk of clients using the court room as a forum to feign mental illness. Secondly, such a provision runs the risk of expending court time and expense on a trial that is ultimately declared null (Stevens and Roesch, 1980). Nonetheless, such option should reside with the defense council.

The period of incapacitation remains problematic. If the accused is not certifiable, should he/she be detained indefinitely when otherwise, upon sentencing, incarceration would be for a fixed period of limited duration? Such thinking suggests a maximum period of detainment, not to exceed a comparable sentence length for a comparable conviction. Further adjustment accommodating for mandatory supervision and projected release date might also be considered. This kind of proviso would be fair, equitable, and eliminate the possibility of being found unfit and then being institutionalized for a much longer period than ones convicted counterparts. A

national survey (Quinsey and Boyd, 1977) reported that the 180 unfit cases located across Canada had already served an average of 83 months at the time of the survey. The scheme does, however, imply guilt in that a fixed maximum period of detainment is prescribed and the term might be misinterpreted to connote a "sentence". These implications are given as the principal reason for not citing a maximum term of opponents of such a proposal. Such a system is recommended, however, because it would make the fitness issue functionally available to all accused. In addition, it remains that further processing, accommodation, and review are handled very differently from those who are convicted. Of course, if one is judged to be fit prior to the maximum term, the case is referred back to court for further judicial processing and adjudication. In the event of a conviction, the sentencing judge would likely consider the period of institutionalization while unfit, as "time served".

The issue of jurisdiction and review should be clear. Although an unfit accused may not be certifiable, his detention at this point is because of mental health considerations (all be they, in a legal context). Therefore, the case remains the responsibility of provincial mental health systems for accommodation and treatment. It seems, however, most logical that review should remain with the jurisdiction responsible for the initial judgement. The use of review boards, as an extension of this jurisdiction, might be questioned, at least in a case of fitness, since it is fitness <u>to stand trial</u> that is still at issue.

Should the prognosis be a factor in determining fitness? Decidedly not. With respect to the rationale of the fitness defense, neither etiology nor the chronic nature of the disorder are at issue. Prognosis may, however, be a relevant issue in psychiatric remand decisions. In the case of acute psychotic episodes, a couple of successive psychiatric remands may be all that is required to successfully treat and divert the accused from an unfitness decision.

The fitness decision entails a procedure for which criteria can be operationalized (Roesch, 1979) and possibly should be considered for more direct inclusion in the Criminal Code. Specific evaluation criteria can and should be developed directly from the fitness principle. This practice can only improve the reliability of assessment while maintaining the validity of the construct (Roesch, 1978).

Although the legal definition of fitness is often equated to the psychiatric term "psychotic" (Roesch, 1978), the two concepts certainly differ. As noted by Jensen (1982), the mentally retarded, severely depressed, hypomanic, and highly anxious may be included in addition to psychotics among the unfit if their mental state sufficiently impairs their capacity to function in court.

Lastly, the following more radical questions are posed for consideration. Is fitness of the accused necessary or is it a concept based on ideological and theoretical principles with little

basis in the reality of legal defense? Is the defendant's sanity truly critical, or even remotely related, to the quality of defense counsel's presentation, or is the protection of an inalienable right sufficient to justify its continued existence?

Insanity

It is not intended to review the lengthy legal history and vast literature on the legal concept of insanity. Instead, a presentation of rationale and resulting implications for applied settings is considered.

The issues of responsibility and insanity are fundamental to the concept of mental health in the legal context (Stevens and Roesch, 1980). As pointed out by the LRC (1977), the intent of the insanity defense is that the "insane" individual be treated as a psychiatric, rather than a criminal problem. Of course, such intent follows the determination that the individual cannot be held criminally responsible. Theoretically, mental disorder may be only one condition which precludes one from criminal responsibility. Therefore, it follows that it may be appropriate for the disposition to vary with the reason for one's lacking responsibility or criminal intent. This may even occur among those found not guilty by reason of insanity (NGRI).

Interpretations and applications of insanity and Section 16 of the Criminal Code have been subject to shifts over time (LRC,

1982). On occasion, interpretation of insanity has been extended beyond "defects of understanding" to cover "defects of will". It is contended that this extension has inserted the thin edge of a potentially vast wedge into the Criminal Code and raises a criterion nightmare with which the judicial system and forensic services have struggled for years. In effect, lack of moral responsibility and affect, the primary characteristics of the psychopath, have rendered many individuals potential Lieutenant Governors Warrant (LGW) cases. In all, personality disorder, which includes psychopathy, comprised 15% of those detained on LGW status across Canada in Quinsey and Boyd's (1977) survey. Interestingly, the LGW make up of personality disorder varied by province from 4% in New Brunswick to 27% in Ontario. This fact attests to the regional differences in the current operationalization of the "responsibility" construct. Although fewer such cases are now being acquitted on grounds of insanity, the provision remains.

An LRC (1982) alternative defines mental disorder as a disease or defect of mind rendering an individual "incapable of appreciating the nature, consequences or unlawfulness of such conduct". This is superior to a second alternative, that would allow for appreciation of the "nature, consequences or moral wrongfulness". The latter alternative provides for psychopathy and impaired control in which case large numbers of currently incarcerated prison inmates might have been eligible. For example, 50% of the maximum security Canadian Penitentiary inmates interviewed in Coburn's (1972) psychiatric survey were diagnosed as psychopaths, although more

conservative estimates, based on strict operational criteria, cite rates of 20% to 30% (Hare, 1980; Wong, 1984).

Another proposal worthy of consideration is the concept of guilt without responsibility, or a "guilty-but insane" status (Allodi, Kedward and Robertson, 1977). Of course, this concept flies straight in the face of the principle of criminal intent. In the context of this phrase, "guilt" refers to having committed the act and probably should be changed to reflect this condition. Regardless, a popular sentiment is that the judicial system should establish a mechanism by which courts can provide for an assessment of evidence and then, having established the facts as to the accused's behaviour, address the question of mental condition. This approach has considerable appeal and may, in fact, be employed informally in many cases. The question is posed whether a formal mechanism might be capable of providing for such an approach? One problem remains, however, that is the possibility of fairly establishing facts of the case (guilt without responsibility) for those who are truly unfit. Presumably, such a mechanism is not applicable to fitness cases.

This position is the polar opposite of that implied by the LRC (1977, 1982) that NGRI be made a "true acquital", subject only to post acquital hearings. However, it is doubtful that the "true acquital" format would differ in its functional outcome for cases of violent offenses, which currently comprise the majority of NGRI's, because of subsequent psychiatric assessments of dangerouness. On

the other hand, such a mechanism would provide "functional accessibility" of the insanity defense to property and other minor offenders.

Lastly, mental status is not simply a diochotomous condition of insane versus insane and the question remains as to what the role of the court might be beyond this basic determination. Historically, the court room has not been viewed as an appropriate forum for an exhaustive clinical case conference. Yet its role continues to evolve. This is evidenced in the Young Offenders Act which allows equal attention to an assessment of offender needs as it does to responsibility and social protection. Is there any reason to consider this model inappropriate for adult cases of mental disorder?

Over the years, mental health professionals have expressed frustration and disgruntlement with the application of mental health concepts in the legal arena. The current procedures pit "hired guns" in an adverserial position, make demands of assessment of dangerousness, and tend to ignore mental health considerations that are irrelevent to the insanity defense. Clearly, much more flexibility is needed if mental health considerations are to be given due process in the court room.

Legal definitions aside, the task of establishing reliable and scientifically valid assessment procedures remains. Although not developed to the same degree of sophistication as fitness tests (Roesch, 1978a; 1978b), development has begun on empirically based

approaches to insanity evaluations. One example is Rogers' Criminal Responsibility Assessment Scales (Rogers, Seman, & Wasyliw, 1983).

Corrections

LGW status may be achived via a third mechanism, that of referral from prison following conviction (CC 546). The Quinsey and Boyd (1977) survey found 50 cases or 17% of the 296 LGW's located across the country came from corrections. Incidence varied tremendously from almost half of the cases in Newfoundland to none in Quebec and Ontario. More recently, however, it appears that this route is utilized infrequently for cases of mental disorder in prison. Secondly, the mechanism is not available for those in federal penitentiaries on the grounds that the court has no power to direct a federally incarcerated offender to a provincial facility (R. v Deans (1977)). Federal authorities are then left with the option of utilizing Section 19 of the Penitentiaries Act and negotiating a Federal/provincial transfer or, if applicable, having the inmate certified and transferred to a provincial mental health facility. In either of these federal cases, the offender is not on LGW status. Instead, these individuals are theoretically deemed to be confined in a penitentiary. Moreover, Section 19(2) of the Penitentiary Act makes provision for a penitentiary warden to "return" a mentally ill inmate to the setting from which he has been received. Although seldom used, this provision in the Penitentiary Act is inconsistent with the rationale for excluding Penitentiary inmates from Section 546 of the Criminal Code (Greenspan, 1983).

The problem of mental disorder among the convicted is of great concern. There are those who "filter" through the Fitness and NGRI 'net' but are clearly disordered. There are those who develop a serious disorder during their incarceration, possibly because of the added stress of prison life. There are those who suffer from a mental condition, are not legally "insane" nor certifiable, but require mental health services. The magnitude of the problem cannot be underestimated. The exact prevalence of psychiatric disorder in prison populations is subject to definitional variance. In spite of this fact, an element of consistency has emerged over time and is described in detail in Part Four of this report. As an example, a series of studies on penitentiary inmates in Canada cite incidence rates of 26% (Chalke, 1973), 23.9% (Roy, Mandelzys and Marceau, 1978) and 24% (Mullen, 1979) as being mentally abnormal and requiring specialized psychiatric facilities and treatment (Wormith, 1979). Legislatively sound and practical solutions are required. Clearly, Section 546 is inconsistent, differentially applied, and an inadequate provision for the problem.

Stated simply, prisons have never been designed for mentally disordered offenders and mental health settings, particularly in current times, are not designed for offenders. Jurisdictional responsibility following sentencing rests with the federal or provincial correctional services, depending on sentence length. There is a disinclination to invoke Section 546 of the Criminal Code or Section 19 of the Penitentiaries Act. Regardless, they are not applicable in the majority of cases. Regional Psychiatric Centres

developed in the last decade by the Correctional Service of Canada and specialized provincial facilities such as the Ontario Correctional Institute represent only a partial solution and cannot begin to accommodate the volume of legitimate cases. In addition, they are clearly correctional institutions in that they are administrated by correctional authorities and fall to their auspices. Mental health certification is a partial solution only in as much as cases can be certified and are acceptable to mental health facilites.

Similarly, the use of federal/provincial transfers for the purpose of psychiatric treatment cited above, depends on the capacity and wilingness of mental health facilities to accommodate such requests. Indeed, it is not unknown for mental health facilities to request a transfer of an LGW patient to a penitentiary for management, treatment, or even work, training, and experience. In this case, the Penitentiary Act makes provision for such a transfer. Our review of CSC's Offender Information System located 8 LGW cases (6 NGRI and 2 unfit) currently in penitentiaries and 2 who have been recently returned to provincial facilities. However, correctional authorities experience administrative difficulties with LGW's as inmates because they lack administrative control for program planning of such events as temporary absence and transfers. This responsibility, of course, remain with the provincial review boards.

The remaining mental health cases in prison are most likely released without benefit of treatment. This group was referred to by a CSC Steering Committee on mentally and behaviourly disordered

inmates (Rama, 1980) as "the gap between CSC and provincial mental health systems".

Community Based Treatment

Community based treatment of offenders tends to be neglected in analyses of the mentally disordered. Such clientele are comprised of those sentenced offenders who pass through a prison setting and those who do not require incarceration. The latter probably represents an underutilized option in the criminal processing of disordered offenders. Rather than having to rely on the judges' "hollow" recommendation for treatment, which carries no authority nor certainty that it will be followed by correctional authorities, a greater provision for community mental health referral could ease the burden and impossible task of mental health services in prison. Such is not a "hospital order" which carries with it its own difficulties, not the least of which is imposition on mental health facilities of unwanted clientele.

At the other end of community corrections, parole officers supervising released offenders have traditionally expressed frustration over inadequate post-release treatment programs for the mentally disordered ex-offender. This may be particularly problematic when the offender is residing in a community half-way house (community correctional centre) or has been transferred from another province during his incarceration and is not considered a provincial resident. The facts of treatment availability and eligibility may

also be taken into consideration when an offender is being assessed for release by paroling agencies. Some disordered offenders released to the community manage to survive their period of supervision and gain an outright release, while others are returned to prison for violation of release conditions. Occasionally, violations are clearly related to mental disorder.

In sum, processing mentally disordered offenders is a complex administrative exercise. Judicial and operational definitions have traditionally been problematic. Jurisdictional responsibility cuts across legal, mental health and correctional systems. Figure 1 is presented in order to illustrate the myriad of routes and decision points through which a mentally disordered offender might pass during his involvement with these systems.

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PART THREE

THE CRIMINALIZATION OF MENTALLY DISORDERED BEHAVIOUR

Background

In the past two decades the mental health systems in North America and the United Kingdom have undergone extensive changes (Allodi, Kedward and Robertson, 1977; Teplin, 1983). The major thrust of the changes concerns the reduction in hospital residency for potential and former mental patients. However, several authors have charged that the changes have been poorly effected and have hence led to a situation whereby persons who would have formerly been treated within the mental health system are now being processed through the criminal justice system (Lamb and Grant, 1982; Whitmer, 1980). This has been termed "the criminalization of mentally disordered behaviour" (Abramson, 1972). From the treatment perspective, this is an alarming phenomenon since the criminal system is poorly designed to handle the mental patient (Teplin, 1983). This section reviews existing theories and data on the proposed criminalization phenomenon.

Social and Historical Factors

Teplin (1983) proposed that three major factors contribute to the criminalization hypothesis. These are the increases in the number of mentally ill persons residing within the community, police

handling of the mentally ill, and the notion of the "forfeited" mental patient (Whitmer, 1980) who cannot gain access to treatment.

There are more mentally disordered persons residing in the community than ever before (Teplin, 1984). To illustrate, from 1962 to 1978 there was an 138% increase in the number of psychiatric discharges across Canada (Statistics Canada, 1964, 1980). This contrasts with a 27% increase in the general population for the same time period (Statistics Canada, 1968, 1980). Total psychiatric discharges across Canada from all facilities is now approaching 200,000 (Statistics Canada, 1981). One reason for this increase is the deinstitutionalization of the mental hospital resident. Deinstitutionalization can be directly attributed to the introduction of phenothiazine derivatives in the 1950's (Allodi et al., 1977), whereby the behavioural control, and hence the large scale release of inpatients, was considered possible. Inpatiency was to be replaced by outpatient treatment at the community level. Table I provides data illustrating the marked reduction of inpatient services in Canada over a twenty year period. Kiesler (1982) has presented similar data for the United States.

A second reason for the increase in the community residence of the mentally disordered concerns the legal context regarding patient rights. Much public concern has been directed toward the deleterious effects of institutionalization, such as the loss of social support networks or the loss of vocational and social competencies (Kiesler, 1982). A related concern was the questionable legality of

Table I

Selected Canadian Mental Health Inpatient Statistics[1]

	1962	1970	1975	11/1980 - 10/1981
Institutions Operating[2]	150	232	289	231
Rated Bed Capacity	70,225	64,758	53,801	20,301
(per 100,000 population)	(380)	(300)	(240)	(80)
Inpatient Days of Care[3]	25.9	21.8	16.5	5.9
Average Number of Inpatients in Reporting Institutions	68,178	59,606	44,847	16,238
(per 100,000 population)	(370)	(280)	(200)	(70)
Average Inpatient Length of Stay[4]				
Psychoses	691	335	181	236
Neurotic and Non-psychotic Disorders	76	53	42	67
All Diagnoses	475	224	159	183
Average Government Inpatient Grants per Institution[5]				
Federal	272.24	95.02	60.19	100.13
Provincial	5,481.11	8,341.09	10,615.69	13,653.87
Other	125.69	509.14	653.33	15.04
Total	5,879.54	8,945.28	11,329.22	13,769.26

[1]All data from Statistics Canada catalogs 83-204, 83-205, 62-002. Data presented are the most recent available at the time this article was written.

[2]Institutions operating comprise all psychiatric facilities, including psychiatric units of general hospitals.

[3]Figures are in millions of days.

[4]All diagnoses according to the International Classification of Diseases (ICD). Psychoses comprise both organic and psychogenic conditions. For 1962 psychoses are classes 020.1, 025, 026.1, 300-309, 648.3 and 688.1 (ICD-7, 1957); for 1970, 1975 and 1980-81 these are classes 290-299 (ICD-8, 1968; ICD-9, 1979). Neurotic and nonpsychotic disorders include all neuroses, personality disorders, substance abuse and all other nonpsychotic disorders, excluding mental retardation. For 1962 these are classes 310-318 and 320-324 (ICD-7, 1957); for 1970 and 1975 these are 300-309 (ICD-8, 1968); for 1980-81 these are classes 300-316 (ICD-9, 1979). Data for 1960-1975 based on discharges alone; 1980-81 data based on discharges and deaths, hence the elevated figures for that year. All figures rounded off to the nearest day.

[5]Figures expressed in terms of thousands of constant dollars (1981=1), to permit direct comparison across years. Other category comprises municipal grants and provincial hospital insurance plans.

involuntary commitment, whereby decisions were based upon incomplete knowledge and incorrect predictions of future dangerous behaviour (Monahan, 1978; Smallacombe, 1981). In response, mental health codes have been enacted with much more stringent committment procedures (Teplin, 1983). Presently, where treatment is given, the least restrictive treatment setting has been adopted as an operating principle (Kiesler, 1983). Moreover, the right of the patient to refuse treatment and live in the community has been established by the U.S. Supreme Court in O'Connor v. Donaldson, (1975). Hence the treatment resistant patient is now often free to live in the community, leaving the mental health system in a paradoxical situation where it has an ethical responsibility to intervene, but a legal responsibility not to intrude (Bonovitz and Bonovitz, 1981).

A third reason for the increasing presence of the mentally ill within the community, at least in the United States, is reductions in mental health program funding. Teplin (1984) notes that with inflation taken into account, federal support for mental health programs in the U.S. has declined since 1975. Moreover, the U.S. Mental Health Services Act, designed to channel money into community mental health services has been repealed (Kiesler, 1983). The result is that, in California for example, 94% of dischargees exist with inadequate outpatient aftercare (Whitmer, 1980).

However, in Canada the funding situation does not appear to be the same. Table I reveals that government support for mental health programs has been increasing steadily over the years, even with

inflation taken into account. Since the ratio of long-term to short-term psychiatric care bed committment has decreased from 1 to 6 in 1970, to 1 to 10 in 1982 (Statistics Canada 1985, 1973), it stands to reason that funds are being directed toward short-term inpatiency. In addition, it has been found that in Ontario, although the average inpatient census has been dropping, admissions comprising voluntary short-term inpatient and outpatient care have been increasing from 1970 to 1979 (Smallacombe, 1981). Hence, the community mental health movement in Canada may not be the relative failure that it is alleged to be in the U.S. This may be explained by an adherence to the principle of universal access to health care by most provinces in Canada, whereby outpatient and community services have been made available and are being used.

In short, policy changes have resulted in the discharge of many mentally disturbed individuals into the community. Unfortunately, with few exceptions (see Kiesler, 1982 for review) the preparation of the patient for noninstitutional life has been poor, and many patients are discharged without treatment (Whitmer, 1980; Lamb and Grant, 1982), or postrelease supervision. However, there is a limit to society's ability to absorb the large numbers of dischargees, particularly since the public generally perceives the mentally ill as being dangerous and unpredictable (Steadman, 1981). Hence, when the mentally ill show symptomatic bizarre behaviour, the public may invoke the criminal justice system to remove them from the community.

The second major component of the criminalization hypothesis concerns the police handling of the mentally ill (Teplin, 1983). In 1959 in the U.K., through numerous state legislations in the U.S., and by the provisions of the Ontario Mental Health Acts of 1967 and 1978, an apprehending officer has the discretionary power to send the individual to jail or to a mental hospital. However, changes in civil commitment proceedings and more limited psychiatric placements have placed bureaucratic obstacles in the way of emergency admittance. Thus, arrest is used as a much less cumbersome method to remove the disruptive mentally disordered. The police cannot be faulted on such a practice. It is their job to maintain order, and often the more expedient method of control will be employed. In addition, where the possibility of mental illness is not recognized by the officer on the scene, inappropriate response to the police by the mentally disordered person may be interpreted as hostility and result in arrest (Teplin, 1984).

The third proposed factor in the criminalization of the mentally ill has to do with the type of clients who are denied admission into the mental health system. One such group is those considered too dangerous for acceptance to treatment, but not dangerous enough to be committed by law (Whitmer, 1980; Teplin, 1984). A second group is the alcoholic who will not be accepted because the mental health staff find that such clients are too disruptive (Teplin, 1984). Another group is those of mixed symptomatology who are denied admission because programs have too narrow parameters to accept them. A good example is the alcoholism centre

that will turn away the alcoholic with a criminal record due to alleged psychopathic tendencies. It may be noted that the American Psychiatric Association (APA) considers criminality a symptom of Antisocial Personality Disorder (301.7; APA, 1980). Moreover, certain mental health facilities will refuse a potential patient with any criminal charge pending, no matter how minor (Teplin, 1983). In all, the finding that substance abuse and psychopathy are the only psychiatric conditions reliably associated with criminality (Guze, Goodwin and Crane, 1969) lends support to the notion of selective exclusion of individuals from mental health programs. If the "forfeited" patients continue to be socially disruptive, but are excluded from psychiatric facilities, they will be readily accepted by the criminal justice system. In effect, it has become the system "that can't say no" (Teplin, 1983, p. 54).

Having presented the argument on the criminalization of the mentally ill, the next section will review empirical studies which have considered the issue. In a general sense, such studies fall into two broad categories, those that investigate the prevalence of mental disorders within criminal institutions and those that assess police encounters with the public.

Prevalence of Mental Disorders Within Correctional Institutions

Studies concerning the prevalence of mental disorders within correctional institutions are largely based on the hydraulic model of Penrose (1939). Now known as Penrose's Law (Bluglass, 1977), the

size of the prison population and the size of the mental hospital population are said to be inversely proportional. In this model, a reduction in mental health housing will be followed by an increase in the prison population, ostensibly because of an influx of former mental patients. Hence, various indicators of mental illness should show increased prevalence in prisons following hospital deinstitutionalization. Penrose (1939) proposed this model after finding a strong negative correlation between prison and mental hospital populations in fourteen European countries.

One type of study in this category examines changes over time in the proportion of individuals with psychiatric histories in jail. Allodi, Kedward and Robertson (1977) noted that reductions in Toronto inpatient facilities between 1969 and 1973 were accompanied by significant increases in the number of persons in jail with prior psychiatric hospitalization. Wormith (1979) noted a fourfold increase in the number of mentally retarded offenders in Correctional Service of Canada (CSC) institutions during the period of deinstitutionalization between 1969 and 1977. In contrast, Smallacombe (1981) observed no increases in the number of persons in jail with prior psychiatric involvement subsequent to the implementation of the 1978 Ontario Mental Health Act amendments. Fleming (1978) obtained results similar to Smallacombe, following the 1976 enactment of the Pennsylvania Mental Health Procedures Act (MHPA). Lastly, no proportional differences were found by Steadman and Ribner (1980) among Albany, New York prison samples taken before and after introduction of the New York Mental Hygiene Act. However,

they did find that for those offenders with any psychiatric history, the average number of previous admissions rose from 1.9 in 1968 to 4.1 in 1975. Clearly, there is disagreement among studies regarding increases in the prevalence of persons with prior mental hospital residency in jails. However, several methodological problems may be noted.

One shortcoming is the reliance on official records and retrospective data. Both Smallacombe (1981) and Wormith (1979) have noted that variations in the creation and maintenance of correctional centre files have consistently undermined research efforts. A second problem is that these studies examined only convicted persons (Teplin, 1983). Even though the diversion mechanisms for moving psychiatric cases from correctional to mental health settings may be poor (Wormith, 1979), the possibility exists that some are transferred to hospitals prior to adjudication. Hence, the number of persons with psychiatric histories will be underrepresented. In such cases investigators will need to study the earlier stages of criminal processing.

A final difficulty with using prior hospitalization as the criterion for mental illness is the exclusion of the mentally disordered who have never been identified as mentally ill or could not get hospitalization and are initially channelled into the correctional system (Teplin, 1983). Since these persons have no record of hospitalization, the number of mentally disordered offenders will

again be underestimated. In sum, all the above factors may have contributed to the conflicting results.

A second type of study which conforms to the hydraulic model addresses changes in the number of referrals and admissions to the psychiatric units of correctional facilities. To the extent that the hydraulic model is valid, steady increases should have been observed over the last number of years, since psychiatric discharges have been increasing (Statistics Canada, 1964, 1980). Studies performed to date support the model.

Allodi et al. (1977) found significant increases in assignments and referrals to the psychiatric unit of the Don Jail between 1969 and 1973. Similarly, Bonovitz and Guy (1979) found that prison staff requests for inmate psychiatric consultation in Philadelphia prisons rose significantly after the implementation of the MHPA (1976) in Pennsylvania. Importantly, Bonovitz and Guy found that the post-MHPA referral group was typically convicted of less serious crimes, such as disorderly conduct and public disturbances, than the pre-MHPA group. Smallacombe (1981) noted a similar trend whereby mentally abnormal offenders in a post-Ontario Mental Health Act (1978) group had committed significantly more public disturbance and minor property offenses than an earlier group. Interestingly, a study in Hong Kong revealed an increase of 51% in the number of prisoners referred to the department's psychiatric centre for psychiatric reports (Lau, 1981) between 1974 and 1977.

The offense-type evidence is compelling in that it suggests that discharged patients experience considerable community adjustment problems. Whitmer (1980) provided an illustrative case example of a 43 year-old discharged schizophrenic woman who was arrested for minor property damage after area residents complained to police about her odd habit of pulling up their garden plants. Since all amended mental health acts specify dangerousness to self and others as the explicit criteria for committment, the implication is that committment and treatment are now reserved for the relatively high profile, dangerous mentally disordered person. In other words, those whose acts could have high media value receive appropriate help, yet those whose acts are relatively less violent and more representative of adjustment difficulties are shunted into the criminal justice system. Such an approach, though politically expedient, is ethically untenable.

This aside, several qualifications are in order regarding the research which utilizes psychiatric referrals as the indicator of mental illness within prison. First, many mental abnormals will go undetected within a prison, since bizarre behaviour is regarded more indifferently in that setting than the same behaviour outside (Teplin, 1983). Hence, extremely disturbed behaviour would have to be exhibited before referral took place. Also, certain types of disorders will go unnoticed, or will even be encouraged by the prison staff since the sufferers will be quiet and withdrawn, thus requiring less supervision. Petrich (1976) provides indirect evidence that this is the case with depressive disorders.

Second, the referral studies do not distinguish between those who become disordered as a result of the stresses of incarceration and those who were abnormal prior to incarceration. Given developments in the understanding of the life-stress-mental disorder relationship, many criminologists have claimed that there is a greater than average incidence of mental "disintegration" during incarceration (Wormith, 1984). Another related point is the demographic notion of "age at risk" for psychiatric disorders. Specifically, there is a high correspondence between the age at which people are at risk for serious mental disorders, particularly psychotic disturbances, and the mean age of the prison population--both being early adulthood. Given the general population baserates for mental disorder, it is possible that a large number of offenders will develop a psychiatric disorder during their incarceration by this coincidence. However, for this hypothesis to be correct, the incidence rate of mental illness for the prison population would have to be higher than that of the general population. The data are equivocal in this regard. To illustrate, the incidence of mental disorder in the general population is estimated to be between 10% and 30% in Canada (Statistics Canada, 1981), and 25% in the United States (President's Commission on Mental Health, 1978). Incidence estimates for prison populations range from 22% to 26% (Monahan, Caldeira and Friedlander, 1979; Roy, Marceau and Mandelzys, 1978; Chalke, 1973). One must note, however, that estimates may be more accurate among the controlled population of a prison, where limited size and closer observation is possible, than among the larger uncontrolled group of the general public.

Third, one cannot be sure if an increase in referrals over time is the result of more mentally disordered persons being in jail, or if it is the result of increased prison staff education in psychiatric problems, whereby all inmates are now alleged to have some form of abnormality. Such a phenomenon is similarly observed among newcomers to the mental health field who find some kind of mental disorder lurking in everyone (Korchin, 1976). In sum, although the referral studies generally support the criminalization hypothesis, several methodological problems render their findings less than conclusive.

Concerning the kind of comparisons made, there is some evidence to suggest that legislation alone is insufficient to modify mental health practitioners. For example, Page (1980) demonstrated that the Ontario Mental Health Act amendment of 1978 did not alter voluntary or involuntary patient admissions nor did it affect the functional criteria used for civil commitment. This study suggests at least a partial explanation for the differences between those studies that investigated the impact of mental health legislation on correctional systems (e.g. Smallacombe, 1981; Fleming, 1978) and the studies that investigated longer term referral rates over time (Allodi, Kedward & Robertson, 1977; Law, 1978; Wormith, 1979). Taken collectively, it appears that changing mental health philosophy is as important as changing statutes in terms of its impact on correctional administrations.

Police Encounters and Decision Making

Investigations in this category comprise two types. The first deals with archival data whereby the arrest rates of former mental patients are compared with those of the general population. The second includes police encounters with the mentally ill and subsequent arrest rates. These studies rely less on retrospective and archival data. To support the criminalization theory it should be found that the mentally disturbed have higher arrest rates, and have had increasing encounters with police over the last 10 to 15 years. The research does support this hypothesis.

In the past it was found that former mental patients had lower arrest rates that the general population (Brill and Malzberg, 1954). However, over the years there has been a shift, and now former mental patients are arrested significantly more often (Steadman, Cocozza and Melick, 1978; Steadman, Vanderwyst and Ribner, 1978). Consistent with the findings of Bonovitz and Guy (1979) and Smallacombe (1981), Steadman et al.'s groups were arrested predominantly for petty crimes, with a very low incidence of violent and sexual infractions. Taken together, these results conform to the criminalization hypothesis.

However, Steadman and his associates reanalyzed their data and found that those former mental patients without prior arrests had a slightly lower rate of future arrest than the general public.

In contrast, former patients with histories of multiple arrests had a much higher probability of arrest. These authors contend that their results do not indicate criminalization of the insane, but rather a situation where recidivistic criminals are also being processed by the mental health system, the so-called "psychiatrization of the criminal". Given their relatively lengthly arrest histories, it will be this subgroup that largely accounts for the consistent finding of higher arrest rates among former mental patients (Steadman et al., 1978).

Despite Steadman et al.'s (1978) assertion, their results do conform to the notion of the criminalization of the mentally disturbed. Specifically, they found that the best predictors of future arrest were total prior arrests, age, and admitting diagnosis. With respect to admitting diagnosis, the only two categories which had appreciable arrest frequencies were personality disorders and substance abuse. Considering what was said earlier about the "forfeited" patient, their characteristic diagnoses and their relative inability to access rehabilitative programs, this finding is not unexpected. In addition, the fact that age and total prior arrests were found to be the best predictors of future arrests is consistent with most criminological investigations of recidivism (Wormith and Goldstone, 1984). However, prior arrest data are especially relevant to the criminalization theory for the following reason.

Teplin (1983) proposed that in cases where mentally disordered persons are more often arrested than hospitalized, the greater the chance of subsequent arrest rather than hospitalization. In other words, if an apprehended person is labelled a criminal rather than mentally disturbed, even for convenience sake by the police, a "master label" phenomenon can arise whereby that person's behaviour will continue to be regarded in criminal and not psychiatric terms. Hence, the potential exists that these persons will remain incarcerated and never, or rarely receive psychiatric care. Of course, this situation is more problematic for the never-diagnosed mentally ill person whose first social service encounter is with the police and not mental health professionals. Such individuals are prone to be rearrested for minor infractions, and hence be relabelled as criminal again and again (Teplin, 1983). Hence, the prevalence of mental disorder tends to be underestimated. In sum, the arrest data appear to support the criminalization hypothesis (Teplin, 1984). However, the notorious inaccuracy of police arrest records render any conclusion tentative.

The second group of studies comprises police encounters with the mentally ill. These studies are revealing in that they indicate to what extent the mentally disturbed come to the attention of the police, and to what extent criminal dispositions are used to control situations involving the mentally ill.

Bonovitz and Bonovitz (1981) observed a 227.6% jump in the number of mental health related incidents coming to the attention of

the Philadelphia police from 1975 to 1979. Unfortunately these authors do not state how the presence of mental disturbance in an incident was determined. It may be noted that the police officers had recently been given training in the recognition of mental disorders. Thus if the presence of mental disorder was police-determined, it is possible that the observed increase was based on the clinical intern phenomenon noted earlier (Korchin, 1976), whereby some degree of mental disturbance is seen in all persons.

In other results, Bonovitz and Bonovitz (1981) found the overall arrest rate in the mental health related incidents to be only 13%, a figure consistent with other incident-arrest rates for all police-citizen encounters, regardless of suspects' perceived mental status (Teplin, 1984). Such a finding would appear to detract from the criminalization hypothesis. However, interviews with police revealed that they were reluctant to arrest the mentally ill, since the district court judges felt such persons should not be jailed for minor offenses. An additional result more consistent with other research was the finding of an 82% jump in disorderly conduct incidents from 1976 to 1979. It was not stated how many of these were mental health related.

In what is probably the best investigation of the criminalization of the mentally disturbed, Teplin (1984) observed Chicago policemen over a 2,200 hour, 14 month period, recording 1,382 police-citizen encounters. The presence of mental disorder in a suspect was determined at the scene by means of a system which took

into account behavioural symptoms, environmental context, and extra-psychiatric cues. The instrument was extensively pretested and proved to be a highly reliable, albeit conservative, device for identifying mental disorder. It was found that 27.9% of the nondisordered, and 46.7% of the mentally disturbed suspects were arrested. Furthermore, the significantly higher arrest rate was observed across all offense categories. As found by other authors (Smallacombe, 1981; Bonovitz and Guy, 1979; Steadman et al., 1978), most of the mentally abnormal were involved in violations of public order, and relatively few in violent crimes.

Teplin (1984) also found that is was a common practice for police to secure a signed incident complaint even if they thought a suspect should be hospitalized. All officers stated that they were aware of restrictive committment procedures, especially for certain types of individuals, and in several cases the signed complaint was used as an alternate disposition after a tour of noncriminal facilities yielded rejections. Hence, Teplin (1984) concludes that the criminal justice system has become the default option when the 'publicness' of the disordered individual's behaviour cannot be overlooked, and civil committment is not possible. In other words, the mentally ill are indeed being criminalized.

A Cautionary Remark and Conclusion

A note should be made regarding differences in the Canadian and American situations. Most studies cited have dealt with American

populations and to some extent their results supported the criminalization thesis. However, only two Canadian studies have been performed recently (Allodi, Kedward & Robertson, 1977; Smallacombe, 1981), and their results were inconclusive.

As noted earlier, the community mental health movement in Canada may not be the relative failure that the American program is alleged to have been. Possible reasons include an increasing instead of decreasing committment of funds, and a system of health care based on the universal access principle. In fact, although hardly conclusive, there is some research indicating that the social integration of discharged Canadian mental patients is higher than the integration of their American counterparts. This has been attributed to superior community care facilities in Canada (Barnes and Toews, 1983). Moreover, there has been a surge in forensic psychiatry in Canada with the opening of the Regional Psychiatric Centres by the Correctional Service of Canada (Roy, 1977), and forensic units by provincial mental health facilities. Hence, the availability of psychiatric treatment for the mentally abnormal offender is increasing. Importantly, the principle of universal access to care is maintained even within Canadian correctional institutions. Given this state of affairs, it is apparent that investigations of the criminalization of the mentally disordered be undertaken to clarify the Canadian situation. Importantly, the Canadian Medical Association has declared that the principle of universal access to health care resources equivalent to those in the

community is a basic right that should never be removed even within our prisons (Wallace, 1974).

Despite the fact that most studies dealing with the criminalization of the mentally disordered are fraught with methodological errors, the evidence tends to support the criminalization hypothesis. Moreover, the one methodologically strong investigation (Teplin, 1984) clearly indicates the streaming of the mentally ill into the criminal justice system. Considering that correctional facilities are not typically designed for a psychiatric clientele, it stands to reason that there will be a burgeoning number of untreated psychiatric clients if de- and noninstitutionalization continues (Allodi, Kedward & Robertson, 1977).

The fact that the criminalization of the insane is taking place can be considered a comment on the failure of the community health movement. In reality, ill-prepared dischargees were left to fend for themselves, and eventually became the wards of an alternate service system (Whitmer, 1980). However, some might question the need for alarm over the situation since the criminalization phenomenon may simply reflect changes in the relative use of two methods for dealing with the socially aberrant (Biles and Mulligan, 1973). In the end, society finances both systems, and it may even be less expensive to detain persons in jail. However, to the extent that society subscribes to a rehabilitative model, the mentally ill must be put in facilities which specialize in their care.

PART FOUR

THE SENTENCED MENTALLY DISORDERED OFFENDER

The Need for Attention

Social scientists have focussed on the "forensic" issues of the mentally disordered offender (Arboleda-Florez, Gupta, and Alcock, 1975; Schiffer, 1978), specifically competency in the U.S. (Roesh and Golding, 1980; Mowbrey 1979; Steadman, 1979) or fitness in Canada (Lindsay, 1976; Roesch, 1978a), insanity (Law Reform Commission of Canada, 1977; Goldstein 1967, Pasewark, 1981; Tanay, 1981) and, to a lesser extent, mentally disordered sex offenders (Konecni, Malcahy and Ebbesen, 1980; Sturgeon and Taylor, 1980).

Mental health problems of prison inmates that develop after sentencing, do not qualify for special provisions, or are not detected until after sentencing and incarceration (Gearing, Hecker, and Mattey, 1980; Halleck, 1961) have commanded less public and research attention (Hartstone, Steadman, Robbins and Monahan, 1984). Nonetheless, estimated at 68% in the United States in 1978 (Steadman, Monahan, Hartstone, Davis and Robbins, 1982), they constitute the largest single category of mentally disordered offenders admitted to mental health facilities.

Mentally disordered inmates in prison have always presented a special management problem. For example, Uhlig (1976) identified

356 inmates of New England prisons who had been identified by the institutions as special management problems. He then found that 53% were diagnosed as having current psychiatric disturbances. Similarly, mentally disordered offenders present a management problem as they are easily victimized (Hartstone et al., 1984) and often require special facilities for their own protection (Tellier, Wormith and Gendreau, 1984). Although conclusive data are not yet available, there is a strong suggestion that they are over represented in protective custody facilities (Brodsky, 1984; Wilson, 1983; Wormith, 1985). The disturbed disruptive inmate also presents special management and treatment problems that traditional correctional facilities are incapable of accommodating (Hartstone et al., 1984). This is confirmed by Tock's (1982) report that they are disproportionately subjected to "bus therapy" which is the correctional counterpart of the mental health "revolving door" syndrome and is really an admission of failure to provide adequate service.

It appears that the mental health-corrections interface, although not without its problems, has been more active and possibly more successful in the United States. In a 1978 survey, 10,831 inmates were transferred from State prisons to separate mental health units (Steadman, Monahan, Hartstone, Davis and Robbins, 1982). In terms of facilities and responsibility, the same survey revealed that 28 states transferred the majority (at least 75%) of their mentally disordered inmates into mental health facilities operated by the state department of mental health, 16 states to

facilities administered by the state department of corrections, and the remaining states referred to both types of units.

In a subsequent analysis, the transfer policy and practice was examined in detail in five states that use department of corrections facilities. Although there was a general agreement across states among staff and administrators that too few inmates are transferred to mental health facilities (48% too few, 8% too many), there was also general agreement (85%) that once the offender is identified as mentally ill, the procedures for transfer work well and that the correctional mental health staff were receptive.

Prevalance in Prison

The issue of mental disorder prevalance rates has been a tremendous source of confusion for decades. For example, Samuel Butler's philosophy expressed by the citizens of Erewhon that crime itself is an illness necessitating treatment is reflected in Abrahamsen's (1952) claim that he has never found a single criminal who did not have symptoms of mental pathology. Similar claims assert that mental illness and criminality are "two sides of the same coin" (Bauer, 1970), that mental illness is a major factor in the incidence of violent crime (Paull & Malek, 1974) and that 85% of a prison sample suffered from "character and behaviour disorders" (Schlesslinger and Blau, 1957). At the other extreme, Overholser (1935) indicated that 85% of his sample was normal. A single British Study (Orr, 1978) noted that prison medical officers cite

rates that range from 10% to 50%, although the number of hospital orders actually prepared represented only 2.2% of the inmate population. These and other mental disorder studies are listed in Table 2 to illustrate the wide range of prevalance rates that have been cited in the literature over the years.

The huge difference in rate of mental disorder is due to three major factors: one, variations in the type of disorders included and the criteria employed; two, different metholodogies and means of assessment; and three, variations in true prevalance rates. More recently, these issues have been addressed, more thorough research has been undertaken, and some consistencies are starting to emerge from the original semantic and methodological jungle.

The emerging clarity is most readily seen in a comparison between Brodsky's (1972, 1973) early report of 9 mental disorder studies in American prisons and Monahan and Steadman's (1983; Hartstone, Steadman, Robbins and Monahan, 1984) more recent analysis. Sampling has become more representative and is no longer based on highly biased samples (Abrahamsen, 1952; Lewis, Balla, and Sacks, 1973) that were caused by the more dramatic criminals being referred for a complete psychiatric diagnosis (Lewis, 1976). Secondly, diagnostic criteria are becoming more stringent and objective while specialized clinicians are developing more accurate means of assessing offenders (Back-y-Rita, 1974). For example, Guze (1976) in his well known study, employed the presence of any two of five behavioural manifestations to define sociopathy. This led to

an incidence of 78% among male felons in the U.S. The American Psychiatric Association's (APA, 1980) Diagnostic and Statistical Manual (DSM III) now imposes a list of ten necessary and independent indicators for the diagnosis of Antisocial Personality Disorder while Hare (1980) has developed an even more stringent scheme based on a behavioural checklist of 22 items.

The question as to what kinds of disorder qualify for inclusion has led to various breakdowns. A single practical approach was developed by Monahan and Steadman (1983) after completing their review of the literature. These authors considered serious mental disorders, specifically the psychoses, and less severe forms of mental illness, such as the nonpsychotic mental disorders and the personality disorders that still warranted mental health treatment. They specifically exclude alcohol and drug dependence. The results of their review of true prevalance rates in jails and prisons suggests that from 1 to 7 per cent of incarcerated offenders suffer from a serious mental illness, such as psychoses, and 15-20 per cent experienced less severe forms of mental illness, specifically the nonpsychotic mental disorders and personality disorders.

Where possible, Table 2 conforms to Monahan and Steadman's (1983) general nomenclature and breakdown of disorder types. Six of the 23 studies are Canadian. Collectively, the studies support the contention that in general inmate populations, 5% can be estimated as having serious or psychiatric illnesses that require specialized care and 20% who experience less severe mental and personality disorders that deserve treatment.

TABLE 2.

Prevalence Rates of Mental Disorder
in Offender Populations

Author	Year	Sample Size	Population	Severe (Psychotic)	Less Serious (nonpsychotic) personality disorder
Glueck	1918	608	New York State Prisoners	12% psychotic mentally deter.....	28% mentally retarded
Overholser	1935	5,000	Massachusetts	------- 15% 'abnormal'---------	
Bromberg & Thompson	1937	9,958	Court of Sessions, New	1.5% psychotic minded	6.9% psyco-neurotic 6.9% psychopathic
Schilder	1940	na.	Convicted felons New York City Court of General Sessions	1.6% psychotic 3.1% Feeble-minded	4.2 Neurotic 7.3% psyco-pathic
Banay	1941	na.	New York State prisoners	1.0% psychotic	17% psycopathic 20% emotionally immature
Poindexter	1955	100	State pen. problem inmates	------- 20% mentally ill ------	
Schlessinger & Blau	1957	500	military offenders	---- 85% character and behavior disorders ----------	
Shands	1958	1,720	North Carolina felons	3.5% psychotic	55.8% personality 3.9% psyconeurotic 7.0% sociopathic 19.89% transient personality disorder 5.3 Other
Bromberg	1961	60,000	New York Felons (132-1957)	-----20% psychotic, neurotic or psychopathic ----------	
Roth (Roth & Ervin)	1971 (1980)	Complete population	A U.S. federal penitentiary Pennsylvania	5% psychoses	15-20% "sufficient psychiatric pathology to warrant attention"
Chalke	1973	Complete population	Canadian Penitentiary Service	5.1% chronic	5.1% acute/subacute 16% personality disorder, alcohol and drugs

Author	Year	Sample Size	Population	Severe (Psychotic)	Less Serious (nonpsychotic) personality disorder
Bolton	1976	1,000	California County jails	6.7% psychotic	9.3% nonpsychotic disorder 21% personality disorder
Guze	1976	233	male felons St. Louis	1% schitzo-phrenic	54% alcoholic 5% drug dependent 78% sociopathic
Swank & Winer	1976	100	Colorado County jail	5% psychotic	13% antisocial personality 16% other personality disorder
Shuckit, Herrman and Shuckit	1977	199	California County jail	3% affective psychotic 3% organic brain syndrome	16% antisocial personality 15% alcoholism 12% drug abuse
Orr	1978	Complete population 42,000	British prisons	----10%-50% subnormal, inadequate and treatable psychopaths---	
Roy, & Marceau & Mandelzys	1978	Complete population 1112	5 Canadian penitentiaries (Pacific)	-----23.9% require or received psychiatric treatment---	
Mullen	1979	Complete population	4 Canadian penitentiaries (Prairies)	3.5% psychotic .4% retarded	24% nonpscyhotic mental disorder (including 5.1% pers. dis. 3.6% neurosis 2.7% alcoholism) 6.4% require treatment
Davidson & Brown	1980	184	Canadian penitentiaries (Ontario)	4.9% Thought Disorder 1.0% Organic Disorder	14.1% personality disorder 7.6% Neurotic
O'Keefe	1980	995	Massachusetts county jails	4.6 "commitable"	6.2% "signs of mental illness"
James Gregory Jones Rundell	1980	1080 admissions over 6 months	Oklahoma prisons	5% Schizophrenia	35% personality disorder

Author	Year	Sample Size	Population	Severe (Psychotic)	Less Serious (nonpsychotic) personality disorder
Borgira	1981	Complete population	County jail Chicago	4% psychotic, suicidal, manic-depressive, toxic state	
cited (Ernst & Whinney)	1982	Complete Population (Ontario)	5 provincial prisons	---- 26.9% diagnosis of mental disorder ----------	
Crane	1982	Complete population 1979-1981	3 Canadian penitentiaries (Atlantic)	---- 21% some sort of mental disorder ----------	

Adapted from Brodsky (1973), Monahan and Steadman (1983), Lillyquist (1980), Ernst and Whinney (1982), Roth (1980) and Wormith (1979).

Finally, discrepancy in rate may reflect actual differences in the true rates of mental disorder across correctional jurisdictions (Monahan and Steadman, 1983). For example, in Canada where jurisdiction is related to sentence, or offense severity, it is conceivable that the prevalance of mental disorder could vary across jurisdictions for at least two reasons. First, if mental disorder is more prevalent in less serious offenses (Teplin, 1984), one would expect to see lower rates in federal penitentiaries. Similary, one might speculate that the court-related filter mechanisms of fitness and NGRI are not applied so vigorously to minor criminals because of the severe consequences. This selective screening would lead to higher disorder rates in provincial correctional facilities. On the other hand, pretrial diversion of the mentally disordered might be more easily implemented with minor, nonvioilent offenders in that mental health facilities might be more receptivew and capable of handling this type of clientele. Finally, differential uses of the LGW status across provinces (Quinsey and Boyd, 1977) could create regional differences. Therefore, some variability between jurisdiction and even between regions or institutions should be expected. Fluctuations within a given facility will reflect true differences in the community only if qualifying disorders are kept constant and the identifying criteria are objectively specified.

Sources of Mental Disorder Among the Incarcerated

Debate as to the precise incidence of mental disorder in prison has continued for decades (Overholser, 1935, Schlessinger and Blau, 1957). Clearly, much of the confusion and disagreement has been due to problems of definition and operationalization. Regardless, every prison-based clinician will agree there are some offenders in every major institution who are mentally disordered to the extent that they need special care and treatment.

There are at least three principal reasons why mentally ill and retarded offenders may be found in prison. They may be described as the naturally occurring incidence of mental disorder, the effect of stress and environmental conditions on mental health, and the less than complete screening of mental disorder at the court level. A brief explanation of each reason follows.

Firstly, Statistics Canada (1981) estimates that 10% to 30% of our Canadian population, depending on one's definition, experience some form of mental disorder. The base rate of acute psychotic episodes, the fact that mental disorder onset often coincides with the age at which people are at risk for crime, and the sheer volume of incarcerated individuals, will dictate that a sizeable number of incarcerated offenders will develop a major psychiatric disorder during their incarceration.

Given the socioeconomic background of the average offender, demographic data would suggest that the rate of mental disorder among prisoners would be even higher than the national average (Monahan and Steadman, 1983). The inverse relationship between social class and rate of psychological disorder is well established, although the direction of causality has not yet been completely determined (Dohrenwend and Dohrenwend, 1969). A U.S. study for the President's Commission on Mental Health (Neugebauer, Dohrenwend and Dohrenwend, 1980) found that psychotic illnesses were 2.58 times more prevalent in the lowest class than the highest social class, while the rate of personality disorder was 3.3 times higher in the lowest social class. Other studies have confirmed that prisoners are drawn disproportionately from the lower social classes and have led Monahan and Steadman (1983) to conclude that crime and mental disorder are associated because of common demographic factors such as age, gender, and social class.

Secondly, the prison environment is excessively stressful for at least some offenders (Porporino & Zamble, 1984; Zamble Porporino & Kalotay, 1984). Prison violence, an austere physical surrounding, overcrowding, restriction of movement, the trauma of the judicial process and family/community separation may all affect the incarcerated offender in a deleterious manner. As we learn more about the origins of maladaptive behaviour, the life stress-mental disorder relationship, and the additive manner in which environmental events cumulate and psychologically impact on

various species, including humans, one can speculate as to a greater than average incidence of mental or psychiatric disintegration in periods of incarceration.

Thirdly, although there are mental health "filter" mechanisms currently in place within our judicial system, these mechanisms are neither intended nor designed to screen or divert all maladapted offenders from the correctional system. Neither are they capable of doing so. For example, while on remand an accused may be certified if he meets the criteria of the mental health act of the province in which he is held. Typically, this procedure is undertaken so as to provide a reprieve (typically 15 or 30 days), to be treated and recover prior to further court proceedings. Secondly, an accused may be found unfit to stand trial, if at the time of trial he is incapable of conducting his defence (C.C.C. 543). Finally, an accused is found Not Guilty by Reason of Insanity (NGRI), if at the time of the offense, he suffers from a "disease of the mind" that renders him incapable of appreciating the nature of quality of an act or of knowing that it is wrong. Clearly, many of the psychiatrically disordered would not be selected out of the judicial processing by these three mechanisms, even if our diagnostic criteria and assessment procedures were completely reliable and uniformly applied which, of course, they are not.

With an inexact classification system and with criteria differentially applied over time and jurisdiction, errors or misses will occur. In addition, it is a common practice for both the

prosecution and defense to consider the severity of the charges and anticipated sentence, contiguously with the mental health status of the accused. The lengthy period of detainment common to Warrant of the Lieutenant Governor patients is an obvious deterrant for a fitness or NGRI defense and, therefore, other provisions are often sought for less severe offenders suffering from mental illness. This may result in their incarceration.

Section 546, Criminal Code

Section 546 of the Canadian Criminal Code provides the necessary provision for the removal of an "insane, mentally ill, mentally deficient or feeble-minded" offender who is incarcerated in a provincial prison. The disordered inmate is removed to a place of safe keeping named in the Warrant of the Lieutenant Governor (WLG). The individual remains in the designated facility until recovered, at which time he is returned to prison if liable to further custody or is released. Recommendation as to the patient's continued disposition is made by a Board of Review, which is appointed in accordance with Section 547 of C.C.C. that reviews all such cases 6 months after the initial order and every 12 months thereafter. Unlike other cases for which it makes recommendations to the Lieutenant Governor (insanity and fitness cases), the Board is also charged with the responsibility of providing an opinion as to the partial recovery of the individual who is no longer liable to further custody in prison.

Section 19, Penitentiary Act

Section 19 of the Penitentiary Act provides comparable authority for the removal of a mentally ill or defective inmate, housed in a penitentiary. The Act makes provision for the Minister to enter into an agreement with the province to accommodate individuals who have been sentenced to penitentiary and have been found mentally ill or defective (Section 19(1)). Such individuals are deemed to be confined in a penitentiary (Section 19(4)). Alternatively, where no agreement exists a penitentiary, on the advice of a physician or psychiatrist, may refuse to accept a disordered offender, or on the authority of the Commissioner of Penitentiaries, return an inmate to the facility from which he was received (Section 19(2)).

Section 19 of the Penitentiary Act has been employed sparingly with a couple of notable exceptions. Agreements with the provinces of Quebec and Ontario have made possible the transfer of federal psychiatric offenders to the Pinel Institute in Montreal, and the Mental Health Centre in Penetanguishene. Pinel has virtually functioned as the sole psychiatric facility for the Quebec Region of CSC, while Penetanguishene has been used as a special facility in the Ontario Region of CSC when its own Regional Treatment Centre is full or inappropriate to the case. Elsewhere, provincial forensic centres and hospitals are employed for special mental health services, usually short-term care of psychiatric assessment for parole. Such arrangements, however, are few and the use of the

provincial agreement has been sparse. Invoking Section 19(2), the refusal to admit a disordered offender or returning such an offender to provincial facilities, is virtually unheard of. Interestingly, disordered provincial inmates, LGW patients, and psychiatric remand cases are occasionally held in federal penitentiaries, typically Regional Psychiatric Centres, as a result of provincial agreements as is the case in Saskatchewan.

There are many reasons for the minimal flow of federally incarcerated offenders to provincial mental health facilities. Following is a partial list of explanations:

1. inadequate provincial facilities in terms of security;
2. inadequate personnel, in terms of training and security;
3. overburdened with traditional provincial mental health responsibilities;
4. lack of administrative/jurisdictional control over the offender;
5. hesitation on the part of federal authorities, to employ a drastic means of transferring a disordered offender (i.e., exercising of unilateral authority by the federal government to place a federal inmate in a provincial authority);
6. hesitation on the part of provincial authorities to employ drastic means of transferring a disordered provincial inmate to a mental health facility (i.e., putting an inmate

with less than a two-year sentence on an indeterminate sentence);

7. danger to existing programs and patients;
8. lack of mutually acceptable per diems and other cost-related responsibility factors.

Yet, corrections officials continue to bemoan the lack of facilities and procedural options to provide for disordered offenders who have received a carceral sentence.

Options for the Mentally Ill Incarcerated Offender

Following is a list of options that might be considered in relation to the legislative, administrative, and treatment planning for the mentally disordered offender.

1. Hospital Order - a court originated order, upon hearing psychiatric evidence as to the offender's mental status, directing provincial health facilities to assume responsibility.

2. Civil Commitment - relying on provincial Mental Health Acts to certify and civilly commit all persons under common criteria regardless of their legal status (i.e., permitting provincial MHA's to take precedence).

3. Corrections Mental Health responsibility - expanded or redirected use of prison hospitals, health care centres and Regional Psychiatric Centres to accommodate and treat, specifically, the mentally disordered inmate.

4. Status quo - specific arrangements continue to be made on an individual case-by-case basis.

5. Legislated treatment in a specialized facility - Washington's "Sexual Psychopath" model integrating court, treatment and community program.

Washington's "Sexual Psychopath" Model

Although a recent and comprehensive review of interorganizational arrangements for the provision of mental health programs for offenders concluded that there is "no one best" way to organize and provide services (Morrissey, Steadman, Kilburn and Lindsey, 1984), some organizations and state legislatures have developed successful formulae. One example is the sexual offenders program legislated into being by the State of Washington in 1951 (Brecher, 1978; Borzechi, & Wormith, 1984; Denenberg, 1974).

As a group, sexual offenders are a varied group. They include the dangerous, assaultive rapist as well as the meek socially-inadequate and inept child molester; the retarded, as well as the educated professional; the psychopathic antisocial offender with a

long history of previous incarcerations and the prosocial first time offender; the psychiatrically disordered patient and the otherwise normal individual (excepting his abnormal sexual behaviour). Therefore, to consider sexual offenders as a homogeneous group is both simplistic and inaccurate. To consider a common legalistic treatment course would be a disservice to the client and community. Instead, a variety of options should be available.

Currently, services include routine incarceration, incarceration in specialized treatment if such a facility is available, hospitalization, and community-based treatment. It is suggested that the most frequent course is routine incarceration with no, or only token, treatment. A term of probation, where the probation officer must struggle to find some kind of acceptable service, is also a common sentence, particularly for nonviolent sexual offenders. Both hospital and prison-based treatment programs are few, being limited to specialized forensic security hospitals such as the Mental Health Centre at Penetanguishene.

In 1951, the Washington State Legislation passed a law providing for the legal commitment of sexual offenders to State mental hospitals for a 90-day evaluation and subsequent treatment until judged to be safe in the community (Williams, 1971). Following conviction for a sexual offence, the procedure may be enacted by petitition from the prosecution. Upon hospitalization, offenders are assessed for "sexual psychopathy", that is the presence of a form of neurosis or psychopathic personality which predisposes such

a person to the commission of sexual offences in a degree constitution him a menace to the health or safety of others (MacDonald & diFuria, 1971). Although couched in psychiatric terms, sexual psychopathy is clearly a legal term and is not a commonly accepted psychiatric entity. For example, in psychiatric terms neurosis and psychopathy are very different diagnoses (APA, 1980).

The offender is referred to the potential treatment centre for professional and peer evaluations which are undertaken with respect to the legal criteria of the sexual psychopathy law and the offender's treatment amenability. Results are then returned to court. If the hospital and the court find the individual to be a "sexual psychopath", the court is required to commit him for institutional care until found "safe to be at large". Therefore, the decision of discharge is based upon a rational premise of personality and behaviour change, rather than completion of a penalty of fixed duration. However, such legislation assumes an ability to make accurate assessments and release decisions. In 1962, the responsibility for the "safe to be at large" decision was returned to the Superior Court of original commitment, by further legislation, the only modification of the original law to date. This modification introduced a requirement of judicial review and decision by the Superior Court of original commitment "at all major points in the process of evaluation, treatment and management of the offender". In addition to finding the offender a "sexual psychopath", the court is also responsible for determining whether the offender is now "safe to be at large" so that he may be placed on conditional or

work release and whether the offender shall be discharged from the original commitment as a sexual psychopath following treatment and five years of conditional release (MacDonald & diFuria, 1971).

A number of observations should be made concerning the Washington sexual psychopath law and its accompanying program at the Western State Hospital in Fort Steilacoom.

The sexual offender program was developed out of necessity following the legislation. Too often legislators may be hesitant to introduce treatment-related laws when the accompanying clinical services are lacking. Under certain conditions, legislation may be the only means of initiating unavailable services. A unique feature of the legislation is its 90-day assessment period in the potential treatment setting and the necessity of mutual agreement by the courts and clinicians as to treatment suitability.

Initially, sexual offenders were regarded as intruders in a community for sick people, were isolated on locked wards, and were given little else, but security attention from hospital staff. Client discontent with the lack of treatment led to escapes and subsequent pressure to provide a more therapeutic environment. The development of an intensive treatment program occurred because of public and patient pressure. It occurred with virtually no infusion of additional manpower or financial resources. When the Western State Hospital was given statewide responsibility, it assumed the challenge and only then was the magnitude of its need apparent. The

program grew from a population of 20 in 1966 to over 200 by the mid-1970's.

The principal treatment modality remains the same. Patients are in group therapy at least 25 hours a week. Treatment is heavily peer oriented. A therapeutic community style of program is operated tightly by a small staff. Less than 50 staff including a treatment team of 11 are responsible for the care of 200 patients on four wards of a large state hospital.

Although the program is known for its humanistic component, it is very tightly controlled with contingent relationships built into most patient activities and a complex system of graduated liberties. Security is dynamic and peer oriented. In addition, the threat of prison looms overhead. The patients are most familiar with the hardships afforded their kind in prison. The period of confinement is not long in comparison to lengthy prison sentences. Offenders must complete a minimum of 18 months with the average running about 2 years. However, in terms of therapy, the time frame and frequency of group therapy translates to a very intensive program.

A hallmark of the program is its community release component and the capacity of the court to return the sexual offender to court or prison. Patients begin with a work release phase. They are allowed to work or go to school in the community and return to the evening hospital program for a minimum of three weeks. This is

followed by outpatient treatment, which lasts at least 18 months. During this phase, the patient is on a probation order to attend weekly evening psychotherapy groups.

The "sexual psychopath" model in Washington is one legislative and treatment option for sexual offenders. Although in comparison to lengthy prison terms, the period of institutionalization is short, treatment intensity is high and the length of program involvement is long. Clearly, the program is not designed or suited to all sexual offenders. However, the legislation is now responsible for the successful diversion from prisons of approximately one-third of the state's convicted sexual offenders who are, otherwise, bound for a period of traditional incarceration. Although there are many advocates of the Washington model, it should be pointed out that the program has not been seriously evaluated in an empirical sense. Nonetheless, it has been described in some detail in this report as a model that contains some promising legislative and program features that might be considered in the development of policies and services for the disordered offender.

For example, a mutually agreed upon assessment by the court and the potential host facility is crucial to the program's success. In contrast, Canadian consultation on court ordered hospital orders met resounding opposition (LRC, 1977). The basic ingredients of a treatment program must be present and contrary to belief, tremendous resources are not required. A court review process with mental health input is responsible for the administration of the sentence

and the offender's release. A graduated community-based release component, with strings attached, facilitates the offender's reintegration into society while maintaining strict control.

The Washington model may serve as a legislative and administrative model for other types of offenders. In particular, certain types of mental disorder might be more successfully treated and more humanely cared for when a court-originated sentence to a treatment facility is enacted. Such a model would be most suited for particular types of offenders with specific clinical diagnoses. It would be less suited to address issues of fitness and N.G.R.I. Specifically, types of offenders, analagous to the "sexual psychopath", who have committed a specific kind of offence and can be clinically identified, might be considered.

Five offender groups come immediately to mind. One group is the drug addict who, as a result of his addiction, has a long history of property crimes and other drug-related offences. Recent legislative attempts to provide compulsory treatment in British Columbia did not follow the Washington model and were unsuccessful. A second group is the alcoholic offender who, because of his drinking, has lost his job, family, and social supports. Sub-groups include those who turn to crime as a way of life, and those who manage to subsist but have a long history of driving offences and become a threat to the community. Driving While Impaired (DWI) programs have some components that are similar to the Washington model. The violent individual who exhibits no regard for others and displays a

callous, amoral outlook constitutes a third group. His history includes numerous violent offences, and no indication of remorse or a change in lifestyle. Such a group might be similar to those few offenders currently designated as "dangerous offenders" by Canadian legislation (Part 21, Criminal Code). A fourth group is the borderline individual who is not certifiable by provincial mental health standards, nor a candidate for unfitness or N.G.R.I., because he possess a basic, but simple, capacity. Yet he is woefully inadequate or intellectually handicapped, and often commits offences out of frustration, an inability to cope with even minor difficulties, or a lack of basic intellectual and psychological resources to respond appropriately to problem situations. Conceivably, each of these groups could be identified and operationally defined both in terms of their offence history and their psychological attributes. Certainly, the Washington "sexual psychopath" model could be developed for other types of offenders with behaviour and/or psychiatric anomalies.

The Washington model, however, is only one example of the many sexual offender statutes. In the U.S., 27 states have provided special disposition procedures for people who have a history of sexual offences although 8 states have recently repealed their acts. Favole's (1983) compendium illustrates the wide range of possible statutes. They range from civil (Illinois) to criminal proceedings (Nebraska). Hearings may occur after a defendent is charged (Illinois), after conviction but before sentencing (Massachussets), or 90 days prior to the expiration of sentence (Georgia). Some

definitions require a mental defect or disorder (California) while others require a finding that one is not insane (District of Columbia). In Canada, the Dangerous Sexual Offender (DSO) was replaced by Dangerous Offender (DO) legislation which expands the statute to include nonsexual violence. However, only 47 offenders have been declared DOs since its inception in 1977. This modification is similar to the experience in Minnesota where their Sexual Offenders Act was repealed in 1980 while "psychopathic personality" statutes with respect to sexual conduct were retained.

The principle of legislated treatment raises a number of specific issues that concern the mentally disordered convicted offender. Three particularly troublesome issues are the concepts of psychopathy, dangerousness, and treatment resistance.

Psychopathy

It is contended that neither psychopathy, as defined by Cleckley's (1941) original 16 criteria, nor a diagnosis of antisocial personality disorder, as outlined in DSM-III (American Psychiatric Association, 1980), should in themselves qualify one for LGW status.

However, the development of DSM-III (American Psychiatric Association, 1980) as a multiaxial diagnostic scheme renders the likelihood of medical psychiatric approximation to the legal term "disease of the mind" greater than ever before. This is because the

system provides a classification scheme that presents clinical syndromes (Axis I) and personality disorders (Axis II) on two independent dimensions.

Pure psychopathy is not sufficient to render one incapable of intellectually understanding the nature and repercussions of one's behaviour even though the disorder may be of biological or physiological origin (Hare, 1970). Clearly, etiology is not at issue. There are numerous medical conditions and abnormalities that affect behaviour, yet leave a person responsible and capable of decision making. This only leaves the legal concept "defect of will" as a potential defense. Yet the mental health counterpart "self-control" is a relative term, applicable to everything from weight loss to psychotic behaviour. Applied to the psychopath, the term probably falls somewhere between the extremes, suggesting, if anything, the possibility of "diminished responsibility". However, diminished responsibility does not, nor should it, qualify one for LGW status (LRC, 1982). Instead, consideration may be given to a reduction of the charge to a less serious offense. Similarly, it is also doubtful that any other AXIS II diagnosis of personality disorder would qualify one for LGW status without at least a secondary diagnosis on AXIS I. As noted in DSM III, an individual with a psychotic disorder on AXIS I may also have recorded a premormid personality disorder on AXIS II suggesting that one cannot expect the LGW population ever to exclude psychopaths, only that psychopathy need not be a sufficient criterion for inclusion. In contrast, the British Mental Health Act of 1959 described psychopathy as a

persistent mental disorder or disability of mind "which results in abnormally aggressive or seriously irresponsible conduct and requires or is suceptible to medical treatment".

If we return to the "defect of understanding" criterion of mental disorder, the vast majority of psychopaths convicted of serious offences will be incarcerated in the penitentiary system. It also follows that other types of disorder including mild retardation, paraphilia, substance abuse, adjustment disorders, anxiety disorders, and disorders of impulse control will continue to populate correctional facilities.

Dangerousness

A second issue is that of dangerousness and its prediction. Certainly when one considers the psychopath or the mentally disordered offender, the thought of "dangerous" immediately comes to mind. Yet in most respects, these are separate issues. The vast majority of the mentally disordered offenders are not dangerous. Similarly, the violent individual typically is not mentally disordered or even purely psychopathic. Nonetheless, a preponderence of research on dangerousness has been done on the mentally ill (Steadman and Cocozza, 1974; Thornberry and Jacoby, 1979; Pruesse and Quinsey, 1977) who now seem to be implicated almost by association. Generally, these studies reveal that the mentally disordered offender is very unlikely to be dangerous (i.e., a low probability of future violence behaviour). Dangerousness is at issue however,

when mental disorder has clearly played a direct role in one's violent behaviour which, regrettably, often leads to wide-spread media coverage (Steadman and Cocozza, 1978b).

Mental disorder need not be demonstrated in the "dangerous offender" designation of an offender by the court (Section 688). Instead, history of recurring violence and likelihood of future violence constitute the critical criteria. From the inception of this legislation in 1977 to February 1985, only 47 cases were so designated. By contrast, the Correctional Service of Canada has designated over 300 of its inmates to special security status during the same period because of their propensity for violent behaviour and their potential for more of the same in prison. There are two primary reasons for the low number of court adjudicated DOs. The vast majority of truly violent individuals are brought to court for serious offences punishable by lengthy sentences such as life. This makes application for D.O. status of little avail. Secondly, in its original form the legislation placed the burden of proof on the Crown to establish future dangerousness. The expert witness is often reticent to give such testimony because the large situational component (Shah, 1976) and the infrequency of violent events in our society (Quinsey, 1980), render the accurate prediction of violence extremely difficult on a single case basis.

Nonetheless, application of the "dangerousness" concept will continue in spite of statements as to its complexity and warnings of its difficulties. It will be employed in decisions of bail, sen-

tencing, dangerous offender designations, parole, and "gating" of mandatory supervision cases. The importance of dangerousness to such decisions has led Rector (1973) to describe the reliable identification of those who can be predicted to be dangerous as "the greatest unresolved problem the criminal justice system faces".

Treatment Resistence

> "It is indeed rather paradoxical that the cases referred to us by the Judge are the most pathological ones and the most resistant to any educative influence. This is the immediate consequence of the present dualistic system that sees the criminal either as someone to punish or as an abnormal individual whom one temporarily or permanently intrusts to the physicians". (Remy, 1962)

At the risk of ending on a negative note, one must acknowledge a very real issue. Client motivation and consent to treatment is a practical problem faced by all clinicians in corrections. It is easy to beckon for more resources so that the mentally disordered offender will receive his appropriate treatment. Yet, to expect such a simple solution is naive. Many offenders are disinclined to participate and among those who do, many will recidivate.

The success of mental health treatment programs has been a subject of great debate for over 30 years (Eysenck, 1952). If anything is now clear, it is that some mental disorders are more successfully treated than others. Little is known about the

efficacy of programs aimed at the violent individual or the sexual offender, and it is a sorry testimony to the state of the art that the most successful treatment of psychopathy appears to be age.

Secondly, many disordered offenders choose not to participate. Some are "incapable of expressing their acceptance of treatment" (Maclay, 1962), so compulsary detention is necessary. Yet civil commitment is viewed as a last resort and is not applicable to most offenders, nor to many LGW patients. The principle of voluntary treatment is adhered to by CSC's Regional Psychiatric Centres (Rama, 1980). Yet certain populations for whom these facilities were designed to treat, elect not to participate. For example, a CSC survey of sexual offenders (Wormith, 1983) revealed less than half would be interested in any kind of treatment oriented to their offense. Most offenders, having been sentenced, are neither eligible for Dangerous Offender (D.O.) status, nor qualify for certification. In such cases, if the inmate is dangerous and disinclined to treatment, the only option may be to detain him for the maximum period allowed by the sentence and advise law enforcement and mental health authorities upon his release.

These circumstances have led many professionals to despair. Tyce (1977) is convinced that no effective psychiatric intervention exists in our present correctional systems and Shervington (1974) wonders if rehabilitation can ever take place in prison. This pessimism is largely responsible for the fact that there was virtually no increase in the number of full time psyhiatrists in

U.S. State penitentiaries between 1930 and the 1960's (Halleck, 1968).

More recently, however, others have taken up the challenge. The American Medical Association, like Churchill who noted that the measure of a society is how it treats its criminals, has declared that improved medical care for prisoners would not only be a humane course of action, but would also "serve the best interests of society as a whole" (Barclay, 1978). Elsewhere, James and Gregory (1980) have proposed a complete community-mental-health-like system for Oklahoma's Corrections Department, while in Canada adequate or equivalent health care has been declared a prisoner's right (Wallace, 1974). Nonetheless, the provision of effective, appropriate, and ethical mental health service remains the most critical issue in penitentiary medicine (Roy, 1979).

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F I G U R E I

CRIMINAL JUSTICE PROCESSING OF THE MENTALLY DISORDERED OFFENDER