THE DISPOSITION OF NOT CRIMINALLY RESPONSIBLE ACCUSED PERSONS IN BRITISH COLUMBIA: THE IMPACT OF THE WINKO CASE ON THE DECISION-MAKING PROCESS OF THE BRITISH COLUMBIA REVIEW BOARD

by

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ABSTRACT

The purpose of this thesis was to examine the effects of the Supreme Court of Canada's ruling in the *Winko* (1999) case on the decision-making process of the British Columbia Review Board when it is charged with deciding whether or not to grant an absolute discharge to a not-criminally-responsible accused person. Results from the content analysis of 36 written B.C. Review Board decisions and 12 face-to-face interviews indicated that certain risk factors were mentioned more frequently post-*Winko*, such as medication compliance, insight into his/her mental illness, and community support.

Although the Review Board’s intent is to make decisions that are therapeutic in nature, if an accused person receives an absolute discharge, the Board is no longer able to maintain ongoing supervision because it loses its jurisdiction over him/her. Thus, an accused may ‘fall between the cracks’ and not receive the required services within the mental health system.

Keywords:
Not-criminally-responsible on account of mental disorder, *Winko*, Therapeutic Jurisprudence, Absolute Discharge, Review Board
I would like to dedicate this thesis to my parents, Bob and Laura.

Thank you so much for your love and support.

I love you both so very much!
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CHAPTER 1: INTRODUCTION

Introduction

In 1992, Bill C-30 made a number of significant amendments to Canadian Criminal Code provisions dealing with mentally disordered accused persons. Among the most significant amendments, was s. 672.54, which provides the Review Board and the trial court with three options for the disposition of not-criminally-responsible accused persons: these options are an absolute discharge, a conditional discharge or a custodial order. Prior to 1992, the courts had no option but to order not criminally responsible persons to be held indefinitely in strict custody at the pleasure of the Lieutenant Governor (Grant, 1997). In addition, Bill C-30 placed the ultimate decision-making authority concerning the disposition of not-criminally-responsible accused primarily in the hands of the Review Board.

Section 672.54 of the Criminal Code lays out the necessary criteria for the Board to apply in selecting the appropriate disposition. In particular, s. 672.54 (a) indicates that if a person does not constitute a ‘significant threat to the safety of the public’, then the Board is required to give an absolute discharge. In 1999, the Supreme Court of Canada

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1 Where a court or review Board makes a disposition...it shall, taking into consideration the need to protect the public from dangerous persons, the mental condition of the accused, the reintegration of the accused into society and the other needs of the accused, make one of the following dispositions that is the least onerous and least restrictive to the accused:
a) where a verdict of not criminally responsible on account of mental disorder has been rendered in respect of the accused and, in the opinion of the court or Review Board, the accused is not a significant threat to the safety of the public, by order, direct that the accused be discharged absolutely;
b) by order, direct that the accused be discharged subject to such conditions as the court or Review Board considers appropriate; or
c) by order, direct that the accused be detained in custody in a hospital, subject to such conditions as the court or Review Board considers appropriate (Canadian Criminal Code, 2005).
gave a definitive interpretation in *R. v. Winko* of what is meant by ‘significant threat’ (Verdun-Jones, 2002).

**Research Objectives**

The purpose of this study was to examine the effects of the Supreme Court of Canada’s ruling in the *Winko* (1999) case on the decision-making process of the British Columbia Review Board when it is charged with deciding whether or not to grant an absolute discharge to an accused person. Specifically, it was of interest to examine how the Board interpreted and applied the concept of ‘significant threat to the safety of the public’ as per s. 672.54 (a) of the *Canadian Criminal Code*. Furthermore, it was of additional importance to examine the frequency of mention of specific factors within written British Columbia Review Board dispositions and to evaluate their potential importance in the determination of risk. There were two methodological aspects to this exploratory study, the first being a content analysis of 36 pre-existing written decisions, and the second being a set of 12 face-to-face interviews. The documents were divided into three periods: twelve were created pre-*Winko* (1992-1998); 12 were created during the year in which *Winko* was decided (1999); and 12 were created several years following the decision in *Winko* (1999-2004).

Specifically, the researcher was interested in examining the effects of the *Winko* case on the B.C. Review Board. Additionally, it was of interest to examine whether certain risk-related factors were given more weight than others by B.C. Review Board members and whether there had been an increase in the frequency of references made to potential risk factors in the written decisions of the British Columbia Review Board post-*Winko*.
Chapter Overviews

Chapter 2 provides a detailed legal background surrounding mental health law in Canada. It begins with an explanation of Canadian Criminal Code provisions for mentally disordered accused and specifically details s. 672.54 of the Criminal Code. There is a brief discussion surrounding the legal purpose of British Columbia’s only Forensic Psychiatric Hospital, followed by a thorough examination of the legal duties of the British Columbia Review Board. The chapter also discusses the legal process surrounding Review Board hearings. The chapter then follows by detailing the legal situation for not-criminally-responsible accused persons pre and post-Winko.

Chapter 3 offers a literature review of the population of not criminally responsible (NCR) accused persons in British Columbia. Additionally, there is an explanation surrounding the services provided to NCR accused persons at the Forensic Psychiatric Hospital (FPH). The chapter also details the statistics indicating how many NCR accused persons have been absolutely discharged from the forensic system pre and post-Winko. Therapeutic decision-making is then discussed in relation to mentally disordered offenders in the forensic psychiatric system. Lastly, there is an analysis of relevant literature regarding the concept of risk and dangerousness. Specifically, information will be presented about risk assessment tools used within the forensic psychiatric system, including the caveats of using such formal tools.

Chapter 4 describes the theoretical framework surrounding this thesis. Specifically, the concept of Therapeutic Jurisprudence will be discussed with a detailed emphasis on mental health legislation. There will be an introduction to specialized
The chapter then describes the researcher's objectives for the study, in addition to the research questions that were posed. Specifically, it was decided to examine the effects of the ruling of the Supreme Court of Canada in the *Winko* (1999) case on the decision-making process of the British Columbia Review Board when it is charged with deciding whether or not to grant an absolute discharge to an accused person. Additionally, it was considered to be important to examine how the Board interpreted and applied the concept of 'significant threat to the safety of the public' as stipulated in s. 672.54 (a) of the *Canadian Criminal Code*. Furthermore, it decided to examine the frequency of mention of specific factors within written British Columbia Review Board dispositions and to evaluate their potential importance in the determination of risk. The procedural design is then explained, detailing both the 36 written decisions used for the quantitative content analysis and the 12 interviews used for the qualitative portion of the study.

Chapter 5 presents the results of the content analysis and interviews. Specifically, the results of the frequency analysis are provided, followed by the analysis of seven themes that emerged from the interview process.

Chapter 6 presents a detailed analysis of the results found in the study. In particular, the impact of *Winko* is discussed, as well as the manner in which the Review Board interprets and applies 'significant threat to the safety of the public'. There is an examination of the concept of risk and how it is assessed, as well as whether the focus should be on past, present or future risk. There is also an examination of the factors
considered when deciding whether to grant an absolute discharge to an accused person. The clinical and legal divide that became evident throughout the interviews is discussed, as well as the phenomenon of split decisions on the Review Board. Lastly, there is a discussion of the significance of therapeutic decision-making by the members of Review Board.

Chapter 7 concludes the study by discussing the overall implications of the results, the advantages and limitations of the research conducted, recommendations for future research, and the final thoughts of the author.
CHAPTER 2: LEGAL BACKGROUND

Introduction

This chapter examines the special legal framework which applies to mentally disordered persons accused of criminal offences in Canada. First, there is an analysis of the Canadian Criminal Code provisions for individuals deemed not criminally responsible on account of a mental disorder (NCRMD). Second, there follows a detailed discussion of the legal mandate of the Forensic Psychiatric Hospital in Coquitlam and the role that it plays in the care and supervision of NCR accused persons in British Columbia. Third, there is an examination of the Criminal Code provisions relating to the British Columbia Review Board and a discussion of its critical role in making dispositions concerning NCR accused persons. Fourth, there is an analysis of pertinent court cases dealing with the disposition of NCR accused persons, with particular emphasis on decisions of the Supreme Court of Canada.


In order for a defence of NCRMD defence to succeed, the court must be satisfied that the accused is “suffering from a mental disorder that rendered the person incapable of appreciating the nature and quality of the act or omission or of knowing that it is wrong” at the time of the offence (Canadian Criminal Code, s. 16(1)). Section 2 of the Criminal Code, classifies a mental disorder as a ‘disease of the mind’. As a result of
cases such as *Rabey* (1980) and *Stone* (1999), the Supreme Court of Canada has interpreted a disease of the mind as being a condition whose origins or cause are primarily internal, the source being psychological, emotional or organic. Further, it was ascertained in the *Stone* case that the decision of whether “a particular medical condition should be considered a ‘disease of the mind’ is one that is made exclusively by the trial judge, as a *question of law*” (Verdun-Jones, 2002: 54). The NCRMD defence is most frequently raised successfully where the accused person has been diagnosed with psychotic episodes (schizophrenia)\(^2\) or severe depression (bipolar depression)\(^3\): in such conditions, the individual may be in a state of mind where (s)he is unable to fully appreciate the consequences of his or her behaviour. Individuals who suffer from a personality disorder\(^4\) alone may not be able to claim an NCRMD defence if it can be determined that at the time of the index offence, they were still able to appreciate the nature of their behaviour and consequences of their actions (Verdun-Jones, 2002).

\(^2\) According to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV), a psychotic episode occurs when an individual loses touch with reality. More specifically, psychoses can be manifested in the form of at least one or more of these five symptoms: delusions, hallucinations, disorganized speech, disorganized behaviour, and/or negative symptoms (which include a reduction in the amount or the range of emotion articulated verbally or physically). Individuals who are actively suffering from psychotic episodes are often diagnosed with some form of schizophrenia or schizoaffective disorder (psychotic symptoms in addition to mood swings) (Morrison, 1995). For example, paranoid schizophrenia is a common form of schizophrenia, marked by “delusions and auditory hallucinations that often guide a person’s life” (Comer, 1998: 490). Psychotic episodes, however, may also be drug-induced.

\(^3\) Bipolar depression is a *mood disorder* where the individual fluctuates between stages of extreme depression and extreme elation. There are two types of bipolar depression (bipolar I and bipolar II). Bipolar I refers to the most severe swing in mood, where the individual suffers from intense and severe depression and then mania. Bipolar II is similar, although the change in mood does not swing as severely or for as long as in bipolar I.

\(^4\) Personality disorders can be defined as “collections of [personality] traits that have become too rigid and work to [an] individuals' disadvantage, to the point that they impair functioning or cause distress” (Morrison, 1995). The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) [the most recent edition is DSM IV TR] also indicates that the ‘patterns’ in behaviour associated with the disorder(s) are not better explained by another mental disorder or medical condition. Additionally, these patterns have been fixed and have affected the individual for a long time (typically as far back as childhood or adolescence) (Morrison, 1995).
Once a verdict of ‘not-criminally-responsible’ has been returned, the trial judge may make an immediate disposition of the NCR accused person (s. 672.45 (2)) or leave the disposition decision to the Review Board (s. 672.47 (1)) of the Criminal Code. The latter is the typical outcome. Once a case is referred to a Review Board for a disposition, the Board is left with three options in s. 672.54 of the Criminal Code: the options are an absolute discharge, a conditional disposition, and a custodial order. Specifically, s. 672.54 of the Canadian Criminal Code states:

Where a court or Review Board makes a disposition... it shall, taking into consideration the need to protect the public from dangerous persons, the mental condition of the accused, the reintegration of the accused into society and the other needs of the accused, make one of the following dispositions that is the least onerous and least restrictive to the accused:

(a) where a verdict of not criminally responsible on account of mental disorder has been rendered in respect of the accused and, in the opinion of the court or Review Board, the accused is not a significant threat to the safety of the public, by order, direct that the accused be discharged absolutely;

(b) by order, direct that the accused be discharged subject to such conditions as the court or Review Board considers appropriate; or

(c) by order, direct that the accused be detained in custody in a hospital, subject to such conditions as the court or Review Board considers appropriate.

The Forensic Psychiatric Hospital and the B.C. Review Board

The term, 'forensic patient' refers to an individual who has displayed signs or symptoms of “serious psychiatric disturbance and has come in conflict with the law” (British Columbia Schizophrenia Society & Forensic Psychiatric Services Commission, 2004: 5). There are four reasons for which a forensic patient or an accused person may be legally referred to a forensic hospital: (i) for an assessment to determine whether the
accused person is unfit to stand trial (UST)\textsuperscript{5}, or to determine whether an accused person should be deemed not criminally responsible on account of mental disorder (NCRMD); (ii) for treatment after a verdict of UST or NCRMD; (iii) for temporary absences in cases where the accused person is serving a sentence in a provincial prison, have been certified under the Mental Health Act and are referred to the hospital for treatment; or (iv) for bail or probation orders where an accused person is sent to a Regional Clinic under that order (British Columbia Schizophrenia Society & Forensic Psychiatric Services Commission, 2004).

Under s. 672.11 of the \textit{Criminal Code}, an accused person may be remanded to a forensic hospital or to a community forensic psychiatric clinic for an assessment in order to determine: (i) whether (s)he is unfit to stand trial (UST); (ii) whether the accused should be deemed not criminally responsible on account of a mental disorder (NCRMD); (iii) whether in cases where a female is charged with the death of her newborn child, there is reason to believe that the accused was mentally disturbed at the time of the offence; (iv) what the appropriate disposition is for an accused person deemed UST or NCRMD; or (v) whether an order be made under s. 747.1 (1) of the \textit{Criminal Code} in cases where an accused person has been convicted of a criminal offence. If an accused has already been deemed unfit to stand trial (UST), or if they are already found to be

\textsuperscript{5} As stated in s. 2 of the \textit{Canadian Criminal Code}, an accused/offender is expected to be able to understand: (i) the charges laid against him/her; (ii) the potential consequences of the charges; (iii), the roles of the participants, such as the judge and the lawyers; (iv) and also be able to communicate with their counsel regarding the case. If the accused cannot, (s)he may be deemed unfit to stand trial (\textit{Criminal Code of Canada}, 2005 & \textit{R. v. Taylor}, 1992).
NCR, they may be treated within a forensic facility for their mental illness

Additionally, an offender who is currently serving a sentence in prison or jail may also be civilly committed to a forensic hospital and treated temporarily under the B.C. Mental Health Act if there are no services available to them in a regular correctional facility.

Lastly, an accused may be court-ordered to attend a forensic psychiatric regional clinic as a condition of his/her release into the community (British Columbia Schizophrenia Society & Forensic Psychiatric Services Commission, 2004).

If an accused is deemed unfit, (s)he may be detained in a forensic psychiatric hospital until found to be fit. Under s. 672.48(1) of the Criminal Code (CC), the Review Board is obligated to convene in order to review whether or not the accused is fit to return to trial. However, in some instances, the accused may never reach a point where (s)he becomes fit. If this is the case, the Review Board must decide what action to take. For example, if a charge has been laid against an elderly individual suffering from dementia, the accused person may never be competent enough to stand trial. As such, this may result in an eventual judicial stay of proceedings under s. 672.851 of the CC.

6 The Forensic Psychiatric Hospital rely on s. 30 of the B.C. Mental Health Act in order to justify the treatment of an NCR and UST accused persons. Specifically, s. 30 states that “person who, under the Criminal Code, is found not criminally responsible on account of mental disorder or is found unfit on account of mental disorder to stand trial, and who is ordered to be detained in a Provincial mental health facility, must receive care and treatment appropriate to the condition of the person as authorized by the director” (Mental Health Act, RSBC, 1996 c. 288). Section 672.58 is the only provision of the Criminal Code which authorizes compulsory treatment – this is a one-time treatment order for up to 60 days for an unfit accused person. Apart from this unique 60-day order, s. 672.55 designates that neither the court nor the Review Board can order compulsory treatment. As such, the consent of the accused is required for any disposition which includes a treatment condition, or in cases where the Review Board “considers the condition to be reasonable and necessary in the interests of the accused” (Canadian Criminal Code, 2005).

7 A jail typically refers to a provincial facility where the prisoner is serving a sentence that is ‘2 years less a day’ in length. A prison; however, is indicative of a federal institution where the prisoner is serving a sentence that is longer than ‘2 years plus a day’.

8 Section 29 of the B.C. Mental Health Act allows for the transfer and civil commitment of prisoners (both adult and youth) to a mental health facility for temporary treatment (Mental Health Act, RSBC, 1996 c. 288).
The application for a judicial stay of proceedings in such cases resulted from the Supreme Court ruling in *R. v. Demers* (2004), as it was found that, in cases where the accused "is permanently unfit to stand trial [and does not pose a significant threat to the safety of the public], the overriding goal of...Part XX.1 [the protection of the public and treating mentally disordered accused persons fairly and appropriately] is absent and Parliament loses jurisdiction" (*R. v. Demers*, 2004: para. 89). However, if it is found that the accused is fit to stand trial, the Review Board has the authority to have the accused sent back to trial under s. 672.48(2) of the CC. It is at this point that an accused may be deemed not criminally responsible on account of a mental disorder (NCRMD).

**The British Columbia Review Board**

The British Columbia Review Board is a semi-judicial, independent tribunal that consists of a chairperson who has provincial court judge status, a psychiatrist, and typically a social worker. Section 672.38(1) of the *Criminal Code* states the function of a Review Board is "to make or review dispositions concerning any accused in respect of whom a verdict of not criminally responsible by reason of mental disorder or unfit to stand trial is rendered". Specifically, the British Columbia Review Board’s mandate is to "protect public safety while also safeguarding the rights and freedoms of mentally disordered persons who are alleged to have committed an offence" (British Columbia Review Board, 2003b). Additionally, the Review Board has stated their policy objectives concerning Part XX.1 (Appeals) of the *Criminal Code*. These objectives have been derived from the decision of the Supreme Court of Canada in the case of *Winko v. British Columbia* (1999):
The twin goals of Part XX.1 of the Criminal Code of Canada are the protection of the public and treating mentally disordered accused persons fairly and appropriately (British Columbia Review Board, 2003a).

The aim of Part XX.1 is twofold: to improve protection for society against those few mentally disordered accused who are dangerous; and to recognize that mentally disordered offenders need due process, fundamental fairness and need the rights accorded to them for their protection when they come into conflict with the criminal law (British Columbia Review Board, 2003a).

Once a verdict has been reached and if a decision has been made by the trial judge to refer the disposition of an accused to the Review Board, the Board must normally decide the case within 45 days of the court's verdict, as required by s. 672.47(1) of the CC. Subsequently, after the initial hearing, s. 672.81(1) of the CC requires the Board to examine cases that have not been granted an absolute discharge at least once every 12 months (Verdun-Jones, 2000). In 2005, section 672.81(1.1) was added to the Code to provide that a Review Board may extend the time between disposition hearings to a maximum of 24 months if the accused person is represented by counsel and the Crown has also agreed to the extension. For example, if the accused has been found NCRMD for a serious personal injury offence (e.g.: an indictable offence where violence was inflicted upon the victim or the psychological well-being of the victim was endangered), and the condition of the accused is not likely to improve within a year's time, then the Review Board can order the 24-month extension.

In addition to mandatory annual reviews, the CC sets out other circumstances in which a hearing may be held. For example, s. 672.81(2)(a) of the CC states that a mandatory review of the disposition is to be held if there has been an increase in restrictions lasting longer than seven days placed on an accused being detained in custody. Alternatively, s. 672.81(2)(b) of the CC, also under the umbrella of custodial cases, states that an accused may request to have their disposition reviewed before his/her
scheduled date. In addition, s. 672.81(3) of the CC is made available to Review Boards in cases where the accused has subsequently incurred a criminal conviction, unrelated to his/her original index offence, and the trial judge imposed a jail or prison sentence on him/her. This is termed a dual disposition review. The Board is then required to convene in order to assess the current disposition of the accused.

An accused may also request a hearing sooner then his/her scheduled date under s. 672.82(1) of the CC. This request differs from that of s. 672.81(2)(b), in that the accused is not in custody when (s)he requests this discretionary review. For instance, an accused may consider requesting an earlier hearing if (s)he has been successfully residing in the community since the last hearing, and is asking the Board to consider an absolute discharge. The accused is not the only party able to request a discretionary review. Often, the Review Board may give a short order, lasting six months, and then evaluate the progress of the accused again. This may occur if the Board feels that the accused is re integrates and succeeding well in the community, and wishes to review his/her case sooner than in one year’s time.

An enforcement hearing (s. 672.94) is similar to that of 672.81(2), as they are both meant to deal with increases in the restriction of liberty. Unlike s. 672.81(2), s. 672.94 concerns cases where the accused is in the community and then has his/her liberty or privileges restrained as a result of incurring a criminal charge. Section 672.94 is usually initiated after receiving notice pursuant to s. 672.93 (1.1) or (2). Section 672.93 (1.1) applies in cases where a justice releases an accused, and notice is to be given to the Review Board. Alternatively, s. 672.93 (2) would be engaged if an accused is arrested while in the community for a subsequent charge, and the justice is of the belief that the
accused has failed to comply with his/her disposition orders. For example, for every case, there may be conditions with which the accused must comply (e.g. abstaining from drugs or alcohol, or a non-communication/association order with the victim(s)). If the accused is found to be in violation of any of the conditions, the Board has the power to hold a hearing pursuant to s. 672.94 in order to determine what appropriate disposition changes should be made to suit the best interests of the accused and to ensure the safety of the public. If the accused has subsequently been detained in custody for longer than seven days, however, then the Board may choose to hold a hearing pursuant to s. 672.81(2).

The Hearing

All Review Board hearings are open to the public and are voice-recorded so that they may be transcribed at a later date. Support persons for the accused may attend if they wish as well as any victims who may choose to be present. Recent amendments to the Criminal Code now permit victims to read a victim impact statement aloud in court or at a Review Board hearing, provided the reading of the statement does not interfere with the ‘proper administration of justice’ (s. 672.5 (15.1)). The Review Board can still accept a written victim impact statement from a victim stating the harm done to them or the loss suffered. A copy of the written statement is then still required to be provided to prosecutor, and to the accused or their counsel. Additionally, it is now the responsibility

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9 Section 672.5(16) of the Criminal Code (CC) contains the same definition of ‘victim’ as does section 722(4) of the CC. Specifically, a ‘victim’ (a) means a person to whom harm was done or who suffered physical or emotional loss as a result of the commission of the offence; and (b) where the person...is dead, ill or otherwise incapable of making a statement..., includes the spouse of common-law partner or any relative of that person, anyone who is in law or fact the custody of that person or is responsible for the care or support of that person or any department of that person (Criminal Code of Canada, 2005).
of the court or Review Board under s. 672.5 (15.2) of the CC to ensure that the prosecutor and/or the victim are aware of the legal right to prepare an impact statement for the Board if they so choose. The court or Board may also adjourn a hearing pursuant to sections 672.45 and 672.47 of the CC if the victim or prosecutor has requested time to prepare a statement. Lastly, s. 672.5 (13.2) of the CC now requires the Review Board to inform the victim(s) once it has received an updated assessment report with respect to any changes in the mental condition that may ‘provide grounds for the discharge of the accused’. Subsequently, the victim(s) may then submit a statement.

Typically, a Review Board commences a hearing by introducing the accused and the reason why the hearing is being held. Additionally, the Board will normally spend a significant period listening to submissions made by the parties who are present. In many cases, the Board will address the accused personally and speak to him/her regarding his/her progress. Upon the completion of the discussion period and after collecting relevant case information and recommendations from the hospital’s treatment team, the Crown, the defence counsel, psychiatrists, social workers, and any witnesses who are asked to speak, the Board enters into private deliberations, and a decision is usually announced immediately thereafter.

The Review Board examines the evidence associated with the offence as well as the past and present behaviour of the accused. In addition, past, current, and future treatment initiatives, as well as any support services available for the accused in the community are typically taken into consideration (Verdun-Jones, 2000). As aforementioned, there are three decisions that may be made: a custodial order, a conditional discharge, or an absolute discharge (British Columbia Review Board, 2003b).
Ultimately, the Board must reach a decision that balances public safety and the rights of the accused.

It is interesting to note that, prior to 1995, the Review Board often granted a conditional discharge to an accused, yet (s)he still had to remain in custody at a forensic psychiatric hospital. In 1995, however, a B.C. Court of Appeal decision ultimately changed that ability. Now commonly referred to as the Johnson decision or Johnson orders, a Review Board is no longer able to grant a conditional discharge to an accused but then order him/her to remain in custody at a forensic psychiatric hospital (British Columbia (Forensic Psychiatric Institute) v. Johnson, 1995). Today, if a Review Board decides to maintain an accused in custody but have similar conditions to those on a conditional discharge, they may order what is called a broad custody order. In other words, although the accused must reside at a forensic psychiatric hospital, (s)he may be granted several unescorted or escorted temporary absences in the community. Broad custodial orders are common when an accused is very close to being granted a conditional discharge into the community (British Columbia (Forensic Psychiatric Institute) v. Johnson, 1995).

Legal Cases and Changes Leading to the Decision of the Supreme Court of Canada in Winko

R. v. Swain

In the case of R. v. Swain (1991), the accused was charged with assault and aggravated assault on his wife, two-month-old baby daughter and sixteen-month-old son.
Suffering from a psychotic episode\textsuperscript{10} at the time of the offence, the accused entered his own home, covered the windows with a sheet, undressed his son and twirled him upside down on his head, scratched an ‘X’ in his wife’s chest with a meat cleaver and swung his daughter around over his head by her ankles. In addition, he damaged items in the house, and according to his wife’s testimony in court, Swain was apparently talking to spirits and attempting to fight these spirits off (Verdun-Jones, 2002).

When this particular case went to trial, the Crown argued that there was sufficient evidence to demonstrate that the accused was not guilty by reason of insanity. Swain’s defence counsel argued against the Crown’s assertion of the insanity defence, claiming that Swain did not fall within the scope of s. 16(1) and that he was in fact capable of “appreciating the nature and quality of the act...or of knowing that it was wrong” (Canadian Criminal Code, 2005). In other words, defence counsel did not want Swain to be found not guilty by reason of insanity and then held indefinitely in custody, as was the law at that time. This position was adopted because, by the time the trial took place, Swain had already been treated for the psychosis, had recovered and was aware of the nature of his previous acts. However, the trial judge did not agree with the defence counsel and found Swain not guilty by reason of insanity (Verdun-Jones, 2002). As a result of the trial court’s verdict, Swain appealed his case and argued that the indeterminate disposition, based on a blanket presumption of dangerousness, violated sections 7 and 9 of the Canadian Charter of Rights and Freedoms. Swain won his case, and Bill C-30 was subsequently enacted in February of 1992 (Verdun-Jones, 2000).

\textsuperscript{10} See note 2 for a detailed explanation of schizophrenia and psychotic episodes.
The enactment of Bill C-30 introduced several major changes to the *Criminal Code*, some of which include the establishment of independent Review Boards with decision-making powers: these replaced the advisory boards which existed prior to 1992 (Reiss, 1997). The new provisions not only expanded the authority of the Review Boards to make dispositions in relation to not-criminally-responsible accused persons, but also granted courts and Review Boards the option of absolutely discharging NCR accused persons, releasing them to the community on conditions, or holding them in custody in a hospital (Grant, 1997). Prior to 1992, s. 16 of the *Criminal Code* read as follows:

16. (1) No person shall be convicted of an offence in respect of an act or omission on his part while that person was insane.

(2) For the purposes of this section, a person is insane when the person is in a state of natural imbecility or has disease of the mind to an extent that renders the person incapable of appreciating the nature and quality of an act or omission or of knowing that an act or omission is wrong.

(3) A person who has specific delusions, but is in other respects sane, shall not be acquitted on the ground of insanity unless the delusions caused that person to believe in the existence of a state of things that, if indeed, would have justified or excused the act or omission of that person (Canadian Criminal Code, 2005).

After the amendments to the *Criminal Code*, s. 16 now reads as follows:

16.(1) No person is criminally responsible for an act committed or an omission made while suffering from a mental disorder that rendered the person incapable of appreciating the nature and quality of the act or omission or of knowing that it was wrong.

(2) Every person is presumed not to suffer from a mental disorder so as to be exempt from criminal responsibility by virtue of subsection (1), until the contrary is proved on the balance of probabilities.

(3) The burden of proof that an accused was suffering from a mental disorder so as to be exempt from criminal responsibility is on the party that raises the issue.

Prior to the implementation of Bill C-30, it was unlikely that a defendant would raise the defence of not guilty by reason of insanity as a plea, especially in relation to less
serious offences. As the defendants were held indefinitely at the pleasure of the Lieutenant Governor, it did not make sense for an accused to enter that plea if (s)he only committed a petty crime, such as a ‘dine and dash’\textsuperscript{11}. Therefore, the plea was typically reserved for more serious offences such as murder and attempted murder. Once Bill C-30 was passed in 1992, it appeared that the defence of ‘not criminally responsible on account of mental disorder’ (NCRMD) became a more attractive option for an accused (Livingston et al., 2003; Verdun-Jones, 2000).

\textit{R. v. Orlowski.}

In the case of \textit{R. v. Orlowski} (1992), the B.C. Court of Appeal held that, if the Review Board were satisfied that the accused no longer posed a significant threat to the safety of the community, (s)he could then be granted an absolute discharge (Grant, 1997). The conundrum that arose from such a decision was that, if the members of the Board were unsure as to whether or not the accused person posed a risk or a future risk, the Board was then entitled to maintain the accused on a conditional discharge or continue a custody order. In this case, the accused was described as constituting a ‘significant threat’. In addition, the court made it clear that there was no onus on the hospital staff to prove this threat but rather that the Review Board required the submission of unequivocal evidence to demonstrate that the accused was \textit{not} a significant threat (Grant, 1997). This decision placed a great deal of pressure on the Review Boards to determine whether or not the accused should be granted an absolute discharge. Subsequently, few were granted one (Verdun-Jones, 2000).

\textsuperscript{11} A ‘dine and dash’ refers to someone ordering food and/or beverages at a public venue or restaurant, and then leaving the establishment (deliberately or otherwise) without paying the bill.
The Winko case (1999) essentially reversed the decision made in the Orlowski decision (1992). Joseph Ronald Winko had been diagnosed with residual schizophrenia and, in 1983, he was considered not guilty by reason of insanity after attacking two individuals with a knife and then stabbing one of them behind the ear (Schneider, 2000). From 1984 until 1990, Mr. Winko was held in custody at the Forensic Psychiatric Institute in British Columbia (B.C.). After failing to appear at a Review Board hearing in June of 1994, Winko re-admitted himself voluntarily until he recovered, and was extremely cooperative in taking his medication. A month later, he re-entered the community and resided at the Hampton Hotel, which was managed by the Mental Patients Association (Winko v. British Columbia, 1999). A few months later, in September of 1994, Mr. Winko missed a necessary medical injection (an anti-psychotic drug), and once more voluntarily admitted himself to the Forensic Institute a month later. Soon thereafter, he returned to the Hampton Hotel in the community (Winko v. British Columbia, 1999).

At a hearing in 1995, Mr. Winko was granted a conditional discharge by the B.C. Review Board. Mr. Winko had not committed any violent acts since his index offences in 1983, and contended that he deserved an absolute discharge (Schneider, 2000). He argued that the decision to continue to keep him under the jurisdiction of the Board

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12 Residual schizophrenia can be defined by an individual "whose diagnosis of schizophrenia is already established, and who has either been treated or improved spontaneously to the point of no longer having enough symptoms for a diagnosis of active disease" (Morrison, 1995: 158).

13 This case was prior to Bill C-30. In other words, the terminology before the enactment of Bill C-30 was "not guilty by reason of insanity". After Bill C-30 passed in 1992, the terminology changed to "not criminally responsible on account of a mental disorder".
violated sections 7 and 15(1) of the *Charter of Rights and Freedoms*\(^{14}\). Mr. Winko also argued that that there was a *de facto* presumption of dangerousness in the legislation, which required any accused to prove that (s)he was not a significant threat (Grant, 2000).

The British Columbia Court of Appeal affirmed the Review Board’s initial decision and stated that the *Charter* had not been violated. However, the dissenting member of the panel, Williams, J.A, argued that the “legislation imposed a burden of proof on the applicant contrary to s. 7 of the *Charter* that was not justified under section 1” (*Winko v. British Columbia*, 1999: para. 11). As a result, Mr. Winko and several other companion petitioners brought their arguments to the Supreme Court of Canada (*Bese v. British Columbia (Forensic Psychiatric Institute)* (1999), *Orlowski v. British Columbia (Forensic Psychiatric Institute)* (1999), and *R. v. LePage* (1999)).

Following lengthy deliberations, it was decided on June 17\(^{th}\), 1999 by the Supreme Court of Canada that s. 672.54 of the *Criminal Code of Canada* (CCC) did *not* infringe upon sections 7 or 15(1) of the *Canadian Charter of Rights and Freedoms*. Specifically, the Chief Justice for the Supreme Court argued that

Parliament intended to set up an assessment-treatment system that would identify those NCR accused who pose a significant threat to public safety, and treat those accused appropriately while impinging on their liberty rights as minimally as possible, having regard to the particular circumstances of each case (*Winko v. British Columbia*, para. 16, 1999).

Even though the *Charter* appeal was dismissed unanimously, there was a split in the Court in relation to the interpretation of 672.54 of the CCC. A 7:2 majority for the Supreme Court of Canada overruled the decision made in *Orlowski* (1992). Specifically,

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\(^{14}\) *Section 7 of the Charter*: the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice;

*Section 15(1) of the Charter*: every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability (*Canadian Charter of Rights and Freedoms*, 1982).
Justice McLachlin stated that the interpretation of s. 672.54 of the CCC (see Appendix E) should be that only those who pose "a significant threat to the safety of the public" will be subjected to restrictions on their liberty, following a verdict of NCRMD" (Verdun-Jones, 2002: 248). If the Review Board is not positively satisfied that the accused presents a significant threat to the safety of the community, then (s)he must be granted an absolute discharge. Indeed, if the Review Board has any doubt as to this issue, then it must grant an absolute discharge (Schneider, 2000). In other words, the Review Board now has to be satisfied, however arduous the decision-making process may be, that the accused poses a threat to public safety before it may impose a conditional discharge or a custody order. According to Justice McLachlin,

...it becomes clear that absent a finding on the evidence that the NCR accused poses a significant threat to the safety of the public, the court or Review Board must order an absolute discharge. This interpretation is supported by the principle that a statute should be read in a manner that supports compliance with the Charter (Winko v. British Columbia, 1999: para. 48).

Specifically, it was stated by the majority of the Supreme Court that

there must be a real risk of physical or psychological harm...in the sense that this potential harm must be serious. A minuscule risk of a grave harm will not suffice. Similarly, a high risk of trivial harm will not meet the threshold (Winko v. British Columbia, 1999: para. 57).

Additionally, the Supreme Court upheld the view which was expressed by the B.C. Court of Appeal in Chambers (1997): namely, that the harm caused must be criminal in nature. Subsequently, Mr. Winko was granted an absolute discharge.

The Winko case (1999) also clarified the initiatives set forth by Parliament in Part XX.1 of the Criminal Code. Specifically, Justice McLachlin re-iterated that the disposition of NCRMD is not meant to be punitive: rather, it is intended to provide the necessary treatment to an accused. Furthermore, the process is inquisitorial, not
adversarial, and takes place in front of an administrative tribunal, instead of a court. As such, there is no onus or burden placed on the accused to prove his/her lack of dangerousness (Winko v. British Columbia, 1999). Instead, the power that the Board has over an accused can only be exercised if (s)he constitutes a significant threat to the safety of the public, and each determination should be made on an individual basis. As such, the Board cannot presume that an accused poses a significant threat because “such a presumption would be based on a stereotype that all persons with a mental illness are inherently dangerous” (Grant, 2000: 174). Accordingly, the Review Board has the task of not only reviewing evidence that favours the restriction of the accused but also considering all the available evidence that supports the least onerous and least restrictive alternative, even if it is not an absolute discharge (Winko v. British Columbia, 1999). It must be noted, however, that there is still a future connotation in the meaning of ‘threat’ in s. 672.54(a) of the CCC. Thus, this future connotation obliges the Review Board to ascertain during a hearing whether an accused might potentially be a threat to the safety of the public within a reasonable time in the future (Russell, 2004).

Relevant Legal Cases Post-Winko

Since the decision in 1999, there have been no empirical studies of the effects of the Winko case on the decision-making process of the Review Boards. However, there have been several pivotal cases decided by appellate courts which have interpreted and applied the ruling of the Supreme Court of Canada in Winko.
The accused, Terry Owen had been found not guilty by reason of insanity\textsuperscript{15} in 1978 of second-degree murder. At the time of the offence, Owen was in a drug-induced psychotic state and was clinically diagnosed with antisocial personality disorder\textsuperscript{16}, alcoholism, and substance abuse. After several attempts to reside in the community, Owen was convicted of possession of a prohibited weapon, break and enter with the intention of committing an indictable offence, and the possession of property obtained by crime (\textit{R. v. Owen}, 2003). As a dual status offender\textsuperscript{17}, Owen was sentenced to serve time in a correctional facility and was then returned into custody at the Forensic Psychiatric Hospital upon warrant expiry\textsuperscript{18}. A conscious effort to reintegrate Owen into the community was made, despite several violent outbursts in the hospital and continued drug abuse. In 1999, Owen was also convicted of impaired driving. Finally, in 2000, after several attempts at a successful conditional discharge, Owen tested positive in his urine for cannabis and cocaine. At the time, his common-law wife informed the treatment team that he had been using other people’s urine samples so that his tests came back negative (\textit{R. v. Owen}, 2000). As a result, the Review Board could no longer support him in the community “because of the respondent's continued substance abuse and the hospital's need for flexibility ‘to react quickly to known increases in risk’” (\textit{R. v. Owen}, 2003: para. 8).

\textsuperscript{15}See note 13 for a detailed explanation of NGRI.

\textsuperscript{16}Antisocial personality disorder is a “personality disorder characterized by a pervasive pattern of disregard for and violation of other people's rights” (Comer, 1998: 576, as stated in APA, 1994).

\textsuperscript{17}A dual status offender indicates that not only is the accused under the jurisdiction of the forensic system, but also the correctional system. An accused may be deemed NCRMD (not criminally responsible on account of a mental disorder) or UST (unfit to stand trial) and serving a sentence for a previous conviction, or NCRMD or UST and serving a sentence for a subsequent conviction.

\textsuperscript{18}Serving a sentence until warrant expiry means that the offender/accused has served their entire prison or jail sentence in a correctional facility and has not been released earlier on parole.
Owen appealed the decision, stating that the Review Board’s decision violated s. 672.54 of the Criminal Code, which states that the disposition must be the “least onerous and restrictive, having regard to (1) the need to protect the public from dangerous persons, (2) the mental condition of the accused, (3) the reintegration of the accused into society and (4) the other needs of the accused.”. It was argued that that it was not unreasonable for the Board to conclude that the respondent’s demonstrated capacity for violence when taking [drugs], now linked to recent evidence of resumed use of cocaine, rendered him a significant threat to the safety of the public (R. v. Owen, 2003, para. 45).

The majority, however, contended that “the Board had wrongly shifted the focus from the protection of the public to the prevention of the respondent's abuse of alcohol and illegal drugs. It exercised its power to make a disposition for a punitive purpose...” (R. v. Owen, 2003: para. 19). Although new evidence was tendered to support the contention that the accused still posed a significant threat to the safety of the public, the Ontario Court of Appeal rejected the admission of this evidence and ruled that the accused be discharged absolutely. Upon further appeal to the Supreme Court of Canada, it was held that the paranoid psychotic state in which the murder had been committed in 1978, triggered by amphetamine abuse, had apparently subsided. However, while the evidence suggests the respondent was not suffering in 1999 from a "mental disorder" (emphasis added) as required by [Criminal, Code section] 16 and 672.34 to qualify initially for NCR status, the Board in making subsequent dispositions is required by [section] 672.54 to have regard to the NCR person's "mental condition" (emphasis added), which is a term of broader scope, and which in the respondent's case was certainly a relevant consideration for the Board in the spring of 2000 (para. 39).

The Supreme Court ruled that the Ontario Court of Appeal had erred in disallowing the new evidence during the appeal: this evidence indicated that, since the Review Board’s custodial disposition, the accused had assaulted another co-patient in the ward, and had also uttered death threats. The majority of the Supreme Court affirmed the Review
Board’s original disposition and the accused was returned into custody (R. v. Owen, 2003).

**Penetanguishene Mental Health Centre v. Ontario and Pinet v. St. Thomas**

These two cases were decided by the Supreme Court of Canada simultaneously. Given that both cases dealt with similar issues, they are often referred to as companion cases. The primary concern in both appeals was to examine whether the Review Board had failed to properly balance public safety with the rights of the accused. As required by s. 672.54 of the Criminal Code, whatever disposition is chosen by the Review Board must be “the least onerous and least restrictive to the accused”. Prior to these appeals, it was widely believed that this phraseology applied only to the Board’s choice between an absolute discharge, a conditional discharge, and a custodial order.

**Penetanguishene Mental Health Centre v. Ontario**

In this case, the appellant, Pertti Tulikorpi, was found ‘not guilty by reason of insanity’ of assault with a weapon in 1991. His mental health history was quite extensive, as he had been suffering from symptoms of schizophrenia\(^{19}\) since 1986. In addition to his mental health history, his criminal record was also lengthy. His index offence of assault with a weapon required him to be detained in a medium-security facility in Kingston, Ontario\(^{20}\). Several years later, in 1993, the Ontario Review Board directed that he be transferred to Oak Ridge, a maximum-security facility in

\(^{19}\) See note 2 for a detailed explanation of schizophrenia.

\(^{20}\) Unlike British Columbia, Ontario’s forensic facilities range from minimum to maximum-security. Specifically, Ontario offers maximum, double-lock medium (high medium), single-lock medium (regular medium) and minimum (Penetanguishene Mental Health Centre v. Ontario, 2004). In British Columbia, the forensic psychiatric hospital houses all levels of security, and the accused cascades from maximum-security units to minimum-security units, until (s)he receives a discharge into the community.
Penetanguishene (Penetanguishene Mental Health Centre, 2004). The Crown contended the security increase was because Tulikorpi "posed 'a serious management problem' at the medium-security hospital where he refused treatment and behaved inappropriately" (Penetanguishene Mental Health Centre v. Ontario, 2004: para. 6). While at Oak Ridge, Tulikorpi was diagnosed with a substance abuse problem, chronic paranoid schizophrenia\textsuperscript{21}, and a personality disorder\textsuperscript{22} with anti-social traits\textsuperscript{23}. While he resided at the facility, he engaged in physically assaultive and sexually inappropriate behaviour. Tulikorpi also began to state that voices in the television were instructing him not to take his medications, and he was also having troubles with water intoxication\textsuperscript{24} (Penetanguishene Mental Health Centre v. Ontario, 2004).

In July of 2000, the Ontario Review Board decided to transfer Mr. Tulikorpi yet again. The Review Board stated that "the least onerous, least restrictive disposition consistent with managing the appellant and protecting the public, taking into account the relevant factors [and] allowing him hospital and grounds privileges while accompanied by staff" (Penetanguishene Mental Health Centre v. Ontario, 2004: para. 9) was to transfer him to Whitby Mental Health Centre, another medium-security facility. Consequently, Mr. Tulikorpi appealed the reasons motivating the transfer.

\textsuperscript{21} See note 2 for a detailed explanation of schizophrenia.
\textsuperscript{22} See note 4 for a detailed explanation of personality disorders.
\textsuperscript{23} See note 16 for a detailed explanation of anti-social personality disorder.
\textsuperscript{24} Water intoxication (hyponatremia) occurs when the body has an "abnormally low concentration of sodium in the blood" (Vlach, 2001:1). If one consumes an excessive amount of water, it can diminish the levels of sodium and chloride in the body. This may lead to depletion in electrolytes and thus, a possibility of over-hydration (Vlach, 2001). In some cases, it can even be fatal (Vieweg et al., 1985; Loas & Mercier-Guizex, 2002). Many patients suffering from schizophrenia have a tendency to consume large amounts of water. This may be as a result of the anti-psychotic medication that they are placed on, given that one of the side effects is typically a dry mouth (National Institute of Mental Health, 2004). As a result, the patient may crave water. Also, if dopamine receptors are inhibited as a result of medication, the accused may drink mass amounts of water to induce a euphoric or intoxicated-like state (Jawetz, 1999).
In this case, the appellant, Michael Roger Pinet was also found ‘not guilty by reason of insanity’ in 1976 after murdering four of his spouse’s family members in the Northwest Territories. He too was transferred to Oak Ridge, a maximum-security facility in Penetanguishene, Ontario. Pinet had been diagnosed with possessing a personality disorder, displaying characteristics of borderline, narcissistic, and anti-social traits. Pinet also suffered from drug and alcohol abuse, and exhibited sadistic paraphilic tendencies (Pinet v. St. Thomas, 2004).

In 1984, Pinet was transferred to St. Thomas Psychiatric Hospital, a medium-security hospital, where he engaged in a sexual relationship with one of the hospital’s staff members. When the relationship terminated, he became extremely depressed and suicidal. There was even “evidence that he contemplated taking hostages” (Pinet v. St. Thomas, 2004: para. 8). As a result, in October of 1985, he was ordered to return to the maximum-security facility hospital in Penetanguishene. In 1995, a decade later, Mr. Pinet requested that he be returned to St. Thomas’s medium-security hospital. Although it was against the wishes of the St. Thomas treatment team, the Review Board allowed it. In June of 2000, a different Review Board panel accepted the advice of the St. Thomas treatment team, and returned Mr. Pinet to Oak Ridge, Penetanguishene’s maximum-
security hospital (*Pinet v. St. Thomas*, 2004). Subsequently, Mr. Pinet opposed the transfer, and appealed the decision.

**The Legal Issue and the Impact of Winko**

In the case of *Penetanguishene Mental Health Centre v. Ontario* (2004), the issue raised was whether the decision of the Review Board violated s. 7 of the *Canadian Charter of Rights and Freedoms*. Section 7 of the Charter states that "everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice" (*Canadian Criminal Code*, 2005). As previously mentioned, s. 672.54 of the *Criminal Code* states that whatever disposition is ultimately chosen by the Review Board must be "the least onerous and least restrictive to the accused" (*Criminal Code*, 2005). At the time, the Ontario Court of Appeal asserted that the term ‘least onerous and least restrictive’ was only meant to exist for the disposition itself, and not for the restrictions within the disposition.

Additionally, in *Pinet v. St. Thomas* (2004), the issue was similar. According to s. 672.78(1) of the *Criminal Code* (CC),

the court of appeal may allow an appeal against a disposition or placement decision and set aside an order made by the court or Review Board, where the court of appeal is of the opinion that:

(a) it is unreasonable or cannot be supported by the evidence;

(b) it is based on a wrong decision on a question of law; or

(c) there was a miscarriage of justice.

In this specific case, Mr. Pinet argued that the Review Board’s decision was “based on a wrong decision on a question of law” (*Pinet v. St. Thomas*, 2004, para. 24).
As stated in *Winko* (1999), the twin goals of the Review Board are to recognize public safety, and also to take into consideration the best interests of the accused. Public safety should always be held paramount; however, in these cases, both of the accused were in secure custody within a hospital setting. As such, the best interests of the accused were supposed to have taken precedence. A custodial order was imminent, and neither of the accused was requesting an absolute or a conditional discharge. In both cases, it was established by the Supreme Court of Canada that not only should the disposition determined by the Review Board be the 'least onerous and restrictive' (*Winko v. British Columbia*, 1999), but also the restrictions or conditions attached to the disposition should be the 'least onerous and restrictive' (*Penetanguishene Mental Health Centre v. Ontario*, 2004 & *Pinet v. St. Thomas*, 2004). It was argued that the “conditions under which an NCR accused is detained in a mental hospital, can also have serious ramifications for his or her liberty interest” (*Penetanguishene Mental Health Centre v. Ontario*, 2004: para. 24) as the conditions must reflect the four factors listed in s. 672.54 of the *CC* (public safety, mental condition of the accused, other needs of the accused, and the reintegration of the accused into society). This contention had been maintained in *Winko* (1999) when Justice McLachlin stated that “the NCR ‘[s]… liberty will be trammelled no more than is necessary to protect public safety” ([*Winko v. British Columbia*, 1999: para. 71]).

Both cases set an important precedent for Review Boards. Although the *Charter* challenges were dismissed as a result of the reasons set out in *Winko* (1999), the Supreme Court of Canada agreed with Mr. Pinet that the Review Board had erred in their decision to send him back to a maximum-security facility, given that it was *not* the least onerous
or restrictive. As for Mr. Tulikorpi, his claim that his Charter rights were violated, were also dismissed because of Winko; however his case was sent back to the Review Board for an updated assessment. As a result, the Review Board must now be vigilant not only to choose a disposition that is the least onerous and restrictive to an accused, but also to ensure that the conditions or restrictions within the disposition itself are the least onerous and restrictive as well.

*Mazzei v. B.C.*

Mr. Vernon Roy Mazzei was found not guilty by reason of insanity in 1986 after breaking into a house, choking a woman until she lost consciousness, dragging her through broken glass, and then holding a screwdriver to her neck. In total, his index offence charges included several counts of theft, robbery, unlawful confinement, breaking and entering, and lastly, assault with a weapon (*Mazzei v. British Columbia* (Adult Forensic Psychiatric Services), 2004). Mr. Mazzei was of Aboriginal status. He had been diagnosed with chronic paranoid schizophrenia\(^{27}\) in addition to brain damage as a result of his incessant solvent abuse. His brain damage was extensive, such that his cognitive functioning was below that of a normal individual, and it impeded his ability to function well within the community and abide by his conditions while on conditional discharge (*Mazzei v. British Columbia* (Adult Forensic Psychiatric Services), 2004).

Prior to the provincial appeal, Mr. Mazzei had appeared before the Board on 20 separate occasions. Nine of those disposition hearings resulted in conditional discharges. In October of 2001, while living in the community on a conditional discharge, Mr.

\(^{27}\) See note 2 for a detailed explanation of schizophrenia.
Mazzei pleaded guilty to charges of theft under $5000. His conviction resulted in a suspended sentence\(^{28}\) and he was placed on probation for one year, thus making him a dual status offender\(^{29}\). In light of that subsequent conviction, and his breach of conditions while on conditional discharge, a Review Board hearing was scheduled one month later to reconsider his disposition order. In addition to the theft, evidence of continued drug use in the community was presented to the Board. As a result, the Board imposed a short custodial order to be reviewed in six months (Mazzei v. British Columbia (Adult Forensic Psychiatric Services), 2004).

By 2002, Mr. Mazzei had returned several times to the Forensic Psychiatric Hospital for illicit drug use. At a hearing in April of 2002, his counsel stated that Mr. Mazzei had become “quite legendary for his revolving-door experience in the system... [and that] the status quo [was] not working for [him]” (Mazzei v. British Columbia (Adult Forensic Psychiatric Services), 2004: para. 18). The Board agreed that, in fact, Mr. Mazzei was becoming institutionalized but was reluctant to grant a conditional discharge, as they felt that he would certainly relapse into his drug use, thus igniting psychotic symptoms, and posing a risk to the community. Consequently, the Review Board imposed another four-month, short order in custody at the Forensic Psychiatric Hospital (Mazzei v. British Columbia (Adult Forensic Psychiatric Services), 2004).

\(^{28}\) A suspended sentence means that that, although the individual has been convicted of the offence, the sentencing judge has chosen to allow the offender/accused to serve no real sentence, but abide by certain conditions instead within the community. However, if the offender/accused breaks any of the conditions or re-offends, (s)he will serve the remainder of their 'would be' sentence in whatever location the judge chooses.

\(^{29}\) See note 17 for a detailed explanation of a dual status offender.
The disposition to have Mr. Mazzei placed in a custodial setting for another four months was not the basis for the appeal. Instead, it was several of the conditions included within his disposition that were appealed. Specifically, the Board had requested:

i) (condition 8) "that for the accused's next hearing the Director undertake a comprehensive global review of Mr. Mazzei's diagnostic formulations, medications and programs with a view to developing an integrated treatment approach which considers the current treatment impasse and the accused's reluctance to become an active participant in his rehabilitation;

ii) (condition 9) that for his next hearing the Board be provided with an independent assessment of the accused's risk to the public in consideration of the above refocused treatment plan;

iii) (condition 10) [and] that the Director undertake assertive efforts to enroll the accused in a culturally appropriate treatment program; . . . (Mazzei v. British Columbia (Adult Forensic Psychiatric Services), 2004: para. 20).

The Director of the Forensic Psychiatric Hospital appealed these particular conditions, asserting that "the Board does not have jurisdiction to make disposition orders binding anyone other than the NCR accused" (Mazzei v. British Columbia (Adult Forensic Psychiatric Services), 2004: para. 21). Further, it was argued that, even if the Board had the jurisdiction to impose these orders, they were unreasonable.

The respondents, Mr. Mazzei and the Board, urged the Court to consider what Justice McLachlin stated in Winko (1999), specifically, that "the system is inquisitorial. It places the burden of reviewing all relevant evidence on both sides of the case on the court or Review Board" (Mazzei v. British Columbia (Adult Forensic Psychiatric Services), 2004: para. 68). The contention was that conditions 8 and 9 fell within the Board's inquisitorial jurisdiction, which requires the Board to make inquiries and obtain from the Director, who is the party in the best position to provide the information, further evidence relating to the past and expected course of Mr. Mazzei's treatment, the present state of his medical condition, the assessment of risk, and the prospects, if any, for modifications to the individualized treatment of the accused (Mazzei v. British Columbia (Adult Forensic Psychiatric Services), para. 70, 2004).
Counsel for the Director argued that the wording and grammar in s. 672.54 of the *Criminal Code (CC)* did not imply that the Board had any authority to impose conditions, pending a custodial or conditional disposition, on anyone other than the accused. Although s. 672.55(1) of the *CC* states that the Board can order treatment if the accused person consents to it and if, the treatment is 'reasonable and necessary in the interests of the accused', the Director maintained that this decision must be based on evidence provided by experts. The Director further stated that expert evidence typically submitted to the Board is by the professionals who are treating the accused, namely the treatment team and the Director. The Director asserted that it was “implicit in the scheme that the health professionals in the institution where the accused is lodged would be the experts recommending and delivering the treatment. An order requiring them to do so would be redundant” (*Mazzei v. British Columbia* (Adult Forensic Psychiatric Services), 2004: para. 77). The Court of Appeal sided with the Director, and the conditions in question were removed from the disposition order of the accused.

In March 2006, the Supreme Court of Canada overturned the decision of the Mazzei case even though there was no longer a live controversy between the parties. Looking to the French version of s. 672.52 of the *Criminal Code*, the text emphasizes the word 'décision' (meaning decision) when referring to the conditions the Board imposes. In contrast, the English text uses the term 'direct'. The French version denotes that “it is the decision itself which is "subject to" appropriate conditions, rather than the accused himself” (Mazzei, 2006, para. 21). As such, it was argued that if the accused person were the only intended subject of the imposed conditions, then the wording in the French
version would have indicated that the accused was subject to or ‘soumis à’ certain conditions (Mazzei, 2006).

After a thorough analysis, the Supreme Court of Canada overturned the appeal. Specifically, it was determined that, although a Review Board cannot prescribe a specific form of medical treatment or deliver treatment, it does have the power to “make conditions regarding the provision and supervision of medical treatment, and to make such conditions binding on other parties such as hospital authorities” (Mazzei, 2006: para. 67).

*Manitoba (Attorney General) v. Wiebe*

Earl Wiebe was found not criminally responsible on account of a mental disorder in 2001 of murder. Wiebe was diagnosed at trial with borderline personality disorder\(^{30}\), and a few years later, was also diagnosed with anti-social personality disorder\(^{31}\). Once transferred to a secured forensic facility, the Board ordered that Wiebe be “detained in custody in a hospital without the ability to leave the ward unless under supervision” (*Manitoba (Attorney General) v. Wiebe*, 2004: para. 7). This order remained in effect throughout the following disposition one year later. In 2003, Wiebe was transferred to Selkirk Mental Health Centre, and placed in the long-term unit. Upon the third disposition hearing in 2003, the same stringent conditions were still in effect, thus giving rise to the appeal (*Manitoba (Attorney General) v. Wiebe*, 2004).

Testimony provided to the Review Board by Wiebe’s treating psychiatrist, Dr. Willows, effectively questioned the purpose of further treatment, and firmly advocated

\(^{30}\) See note 25 for a detailed explanation for borderline personality disorder.

\(^{31}\) See note 16 for a detailed explanation for anti-social personality disorder.
that Wiebe be held in strict custody. Dr. Willows asserted that "the appellant had threatened to kill other people in the ward, had extorted money and, since he was exhibiting no symptoms of psychosis or post-traumatic stress, that there was nothing for him to treat" (Manitoba (Attorney General) v. Wiebe, 2004: para. 10). Essentially, Dr. Willows advised the Board to cease treatment for the accused. At the time of the appeal, Wiebe was being held in custody in a provincial jail as a result of subsequent charges.

Wiebe's counsel argued that

the Board failed to discharge its duty in not seeking further information on the treatment of [borderline personality disorder] and in failing to commission an outside assessment given the intractability of Dr. Willows and his contrary opinion (contrary to the other specialists who had seen the appellant) with respect to the appellant's treatment (Manitoba (Attorney General) v. Wiebe, 2004: para. 22).

Further, it was contended by Wiebe's counsel that the Board did not follow the principles laid out by Parliament and by Justice McLachlin in Winko (1999), whereby the "accused is to be treated with the utmost dignity and afforded the utmost liberty compatible with his or her situation. The NCR accused is not to be punished" (para. 42). The Manitoba Court of Appeal conceded that the Review Board "made a decision adversely affecting the liberty interest of the appellant without having an adequate factual foundation on which to do so" (Manitoba (Attorney General) v. Wiebe, 2004: para. 34). As a result, it returned the matter to the Review Board, and ordered that the Board reconsider the evidence before them, while following the mandate provided in s. 672.54 of the Criminal Code.
Regina v. Wodajio

The accused, Alebachew Wodajio, was found not guilty by reason of insanity in 1982 for the crime of second degree murder. While in his own home, the accused stabbed his social worker after believing that he was sexually attracted to him, and threatening him sexually. There was no evidence, however, to confirm that suspicion or belief. The accused was subsequently detained in custody at the Alberta Hospital in Edmonton and was diagnosed with schizophrenia. Several complaints were made during Wodajio's detention by other patients that he was sexually assaultive towards them. One of the allegations even led to a criminal charge; however, the charge was stayed (Regina v. Wodajio, 2005).

In 2003, Wodajio was removed from a group home while on a leave of absence, and was returned to the Alberta Hospital in Edmonton for an alleged sexual misconduct towards a female. As a result of the increase in restrictions, a hearing was held in January of 2004 pursuant to s. 672.81(2) of the Criminal Code. During the hearing, evidence from Wodajio's treating psychiatrist was presented to the Board which supported a conditional discharge back to Ethiopia if there were adequate means to monitor him there. The psychiatrist further stated that, if Wodajio were to remain or be returned to Canada, he should be detained in custody because there were "concerns of sexual abuse in the future" (Regina v. Wodajio, 2005: para. 5). Additionally, although

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32 See note 2 for a detailed explanation of schizophrenia.

33 Within the province of British Columbia, police officers do not have the power to lay a charge. Upon an arrest, it is decided by the Crown whether to pursue a charge. Even if a charge is accepted, if the Crown wishes not to pursue the case (i.e.: the proceeding would not be in the name of public interest, or if the situation within the case changes) the charges may be 'stayed'. A stayed charged may be re-opened within the statue of limitations. Alternatively, a charge that is 'withdrawn' by the Crown cannot be re-opened once it is withdrawn from the court.
Wodajio had recently remained compliant with his medication, there was some concern surrounding the possible deterioration in his mental condition if he were not to remain compliant in the future. Additionally, his insight into his mental illness was minimal. Further testimony from his psychiatrist suggested that, even if Mr. Wodajio were to be cured of his mental illness altogether, he would still pose a significant risk of re-offending. The Review Board decided to have the accused remain in custody at the Alberta Hospital in Edmonton and consequently, Mr. Wodajio appealed the decision (Regina v. Wodajio, 2005).

There were three basic issues upon which the appeal was made. The first concerned the unproven allegations of sexual misconduct on behalf of Wodajio and the link to them being a 'significant threat to the safety of the public'. The second issue brought forward was whether the concept of 'significant threat to the safety of the public' (as per s. 672.54) had to be directly linked to the mental illness of the accused. Finally, the third concern was whether the Board had failed to take into account the need for his reintegration into the community and his other needs, as stated in s. 672.54 of the Criminal Code (Regina v. Wodajio, 2005).

The majority for the Alberta Court of Appeal conceded that, regardless of whether or not criminal allegations are true, they are still admissible and pertinent during a hearing. What was stressed, however, was that the credibility of the allegations should be weighed carefully. As for the second issue appealed, it was stated that when referring back to Orlowski v. British Columbia (Attorney General) (1992), Winko v. British Columbia (1999), R. v. Baker (2001), there is a future connotation present, whereby the Board must also take into consideration what the accused will likely do in the future if
released. Therefore, as for the mental condition of the accused and its relation to being a ‘significant threat to the safety of the public, it “must relate to the appellant’s mental condition or overall mental state at the time of the hearing, and does not have to be directly related to his operative mental illness” (Regina v. Wodajio, 2005: para. 46). Lastly, the third issue regarding whether the Board had not taken into account Wodajio’s need for reintegration into the community and his other needs was reviewed. It was asserted that the Board did in fact carefully examine the alternative of Mr. Wodajio being returned to Ethiopia, and that regardless of this option, an absolute or a conditional discharge would not “adequately protect the public the significant threat of further acts of violence” (Regina v. Wodajio, 2005: para. 48). Thus, the appeal was dismissed by the Court of Appeal.

This chapter and the legal cases discussed within it have provided some insight into the role of the Review Board pre-Winko, in addition to the subsequent changes made to the decision-making powers of the Review Board post-Winko. Review Boards have been given more powers and also have the right to impose restrictions. Additionally, they are given deference when acting within their expertise, as they are recognized as a specialized tribunal - as long as the Review Board acts within their jurisdiction, they are not second-guessed. The subsequent chapter will examine the literature surrounding mentally disordered offenders, in addition to exploring the therapeutic value of decision-making within specialized tribunals.
CHAPTER 3: LITERATURE REVIEW

Introduction

This chapter begins by providing an overview of the characteristics of the current NCR accused population in the province of British Columbia. Specifically, the most common index offences which have been committed by NCR accused persons will be discussed in addition to the most prevalent diagnoses associated with these individuals. Second, there is a detailed examination of the mandate of the Forensic Psychiatric Hospital and the services which it is required to provide to NCR accused persons. Third, statistics are provided in order to foster an understanding of forensic case activity both pre and post-Winko. Fourth, research which studied the decision-making process of mental health review tribunals in England and Wales is explored with a view to identifying outcomes which may possibly be considered as “anti-therapeutic.” Finally, the concept of ‘risk’ and ‘dangerousness’ is examined. The major focus is on the function of risk assessments within the forensic system and various critiques regarding their use. This analysis is followed by some forensic case examples incorporating risk-related factors.

The NCR Accused Population in British Columbia

Currently in the province of British Columbia (B.C.), the majority of individuals who are found not criminally responsible on account of a mental disorder (NCRMD)
have committed some form of assault (Livingston et al., 2003). Livingston et al. (2003) found that between 1992 and 1998, the most common index-offence charges were assault (45.5%), nuisance (14.9%), murder or attempted murder (10.5%), and property crimes (10.2%). Slightly over 22% of accused persons were under the influence of drugs or alcohol at the time of the index offence. Livingston’s study also revealed that 39.5% of NCR accused in British Columbia had been diagnosed with schizophrenia\textsuperscript{34}, 19.9% had an organic mental disorder\textsuperscript{35}, 15.6% had a mood disorder\textsuperscript{36}, and 13.4% had a non-specific psychotic disorder. It has also been estimated that anywhere between 15 and 32% of those prisoners serving sentences in non-forensic correctional facilities in the province of B.C. also have some form of mental disorder (Davis, 2006 & Hall, 2000, as stated in British Columbia Schizophrenia Society & Forensic Psychiatric Services Commission, 2004). These statistics are noteworthy since they provide a clear picture of the various offences committed by offenders within the system today. Additionally, they provide some valuable insight into the nature of the criminal behaviours which the Review Board typically confronts.

**Forensic Psychiatric Services**

The Forensic Psychiatric Hospital (FPH), formerly the Forensic Psychiatric Institute, is situated in Port Coquitlam, B.C. and is equipped with over 200 beds for NCR accused persons. It is classified under s. 5 of the *Mental Health Act* as a Mental Health Facility (*Mental Health Act*, 1996). The FPH works in collaboration with six regional

\textsuperscript{34} See note 2 for a detailed explanation of schizophrenia.

\textsuperscript{35} An organic mental disorder occurs when there is physical damage or some type of degeneration in the brain tissue causing a psychological condition (e.g. Alzheimer’s) (Comer, 1998).

\textsuperscript{36} Depressive disorders such as bipolar disorder and post-partum depression are examples of mood disorders. Individuals suffering from mood disorders may feel ‘down’, or may fluctuate between highs and lows (Comer, 1998).
clinics in the province for NCR accused persons who have been granted a conditional discharge. These clinics are located in Vancouver, Victoria, Nanaimo, Prince George, Kamloops, and Surrey. The purpose of these clinics is to “monitor the client’s progress in treatment and ensur[e] that the client is adhering to the conditions set out in the Disposition Order provided by the B.C. Review Board” within the community (Forensic Psychiatric Services Commission, 2003d).

If an accused person is serving a portion of their disposition in custody, a mental and physical assessment is performed and a treatment plan that suits the needs of the accused is immediately initiated. Treatment planning conferences occur regularly in the hospital and the attending psychiatrists, social workers, case-management coordinators, as well as the accused are present to review treatment plans, régimes, and discuss community-reintegration strategies (Forensic Psychiatric Commission Video, 2003b). In addition, individual and group drug and alcohol counselling is offered along with community-discharge planning and referrals once it has been decided by the treatment team and the Review Board that the accused is ready for community reintegration. Other programs offered at the FPH include vocational training, education and schooling with an emphasis on computer skills training. Once an accused person is deemed more stable and progressing more rapidly towards community integration, they eventually cascade to a medium-security independent living housing unit, located on hospital grounds. This operates as a transition between the hospital and a community boarding home (Forensic Psychiatric Commission Video, 2003b).
Statistical Findings (Pre-Winko)

Grant (1997 & 2000) conducted a study prior to the Winko case examining the number of absolute discharges within the province of British Columbia (B.C.). Grant collected all B.C. Review Board dispositions and reasons between 1992 and 1994. Specifically, her objectives were threefold. First, Grant wanted to determine whether there were more individuals claiming the defence of not criminally responsible on account of mental disorder (NCRMD) following the 1992 amendments to the Canadian Criminal Code. Second, Grant also wanted to know if the B.C. Review Board members were utilizing all of the new dispositions provided in the amendments: a custodial order, a conditional discharge, or an absolute discharge. Specifically, Grant was curious as to whether the Board would continue to rely heavily on custodial orders as opposed to alternative community dispositions. Lastly, Grant was interested in the decision-making criteria of the Review Board. For example, were the index offence, gender and clinical diagnosis of the accused, or the determination that the accused constituted a ‘significant threat’ related to the disposition received? Furthermore, Grant inquired into whether or not the decision to grant an absolute discharge was related to where the accused was living, namely in the community or in custody during the time of the hearing.

The results of Grant’s study indicated that, after the amendments in 1992, there was an increase in the number of successful NCRMD defences which were raised by defence counsel: these verdicts resulted in the admission of the NCR accused persons concerned to a forensic psychiatric hospital. For example, in 1990 there were only seven NCR accused admitted to the Forensic Psychiatric Institute in B.C.; however, in 1993 and 1994 38 and 60 NCR accused persons respectively were admitted to the Institute (Grant, 1997 & 2000). Grant found that, between the years 1992 and 1994, approximately 71% of the
NCR accused had committed some crime against a person as their index offence. These findings complement those of Livingston's study (2003) which indicated that the most common index offence committed by an accused person was a crime against a person. Grant's data revealed 45 assaults that ranged from simple to aggravated assault, 10 homicides, six attempted murders, and eight sexual assaults. Property offences, ranging from mischief to causing damage by fire, represented approximately 20% of the cases. Finally, crimes against public order, including possession offences, dangerous driving, and indecent exposure, constituted approximately 9% of the cases. Although there were considerably more males in the forensic system, Grant also found that there was a noteworthy increase in the female forensic population since the amendments to the Criminal Code - from 5.6% of the total population in 1990 to 25% during 1992-1994 (Grant, 2000).

Grant also found that of the 112 NCR accused only one received an absolute discharge (0.9%) in two years, as approximately 67% of all cases received a conditional discharge within that time. It should be noted, however, that this study was conducted in relation to cases brought to the Board prior to the Johnson case (1995): at that time, an accused may have been granted a conditional discharge by the Review Board but still be ordered to remain in custody. Therefore, 67% does not provide an accurate description of the true percentage of conditional dispositions during that time. Instead, it was found that 29.5% of cases were in reality what is now referred to as ‘broad custodial orders’, and 37.5% of cases were true conditional discharges. Lastly, 32.1% of all the cases in the

37 Prior to 1995, it was not uncommon for Review Boards to grant an accused person a conditional discharge, but still order him/her to remain detained in the hospital. In the 1995 ruling of R. v. Johnson, it was determined that a Review Board could no longer detain an accused person within a forensic hospital under a conditional discharge. Rather, an accused person remaining in custody but holding many community privileges would be held under a broad custodial order.
study received custodial orders. Consequently, custodial orders and broad custodial orders (pre-
Johnson conditional discharges) constituted almost 62% of all cases detained in custody (Grant, 2000).

Grant then examined whether certain factors such as 1) index offence, 2) gender, 3) clinical diagnosis, or 4) the determination of significant threat by the Board were predictive of which disposition would be granted to an accused. Results indicated that the first three factors had no predictive power. However, all cases where an accused was deemed to be a 'significant threat' received either a strict or broad custodial order (Grant, 2000).

Lastly, Grant found that of the 37 accused residing in the community at the time of their hearing, one received an absolute discharge, 30 received a true conditional discharge, five received a broad custodial order (a detainable conditional discharge), and one received a strict custody order. Of the 65 accused persons in custody at the time of the hearing, not one received an absolute discharge; however, seven received true conditional discharges, 27 received a broad custodial order, and 33 received strict custody orders (Grant, 2000).

After Grant's study was conducted, the B.C. Review Board provided case information regarding accused persons who had been absolutely discharged by 1996. Analyses indicated two statistically significant results. First, accused persons were more likely to receive an absolute discharge from the Board if their initial disposition was a conditional discharge. Second, there was also an increased likelihood of receiving an absolute discharge if the accused had been diagnosed with a bipolar disorder (Grant, 2000). Thirty-three percent of Grant's sample cases had been diagnosed with
schizophrenia, whereas 20% had been diagnosed with bipolar disorder. Grant asserted that drug treatment may be more successful in bipolar disorder cases, as patient stabilization tends to be more rapid than that of other disorders. As a result, an accused suffering from a bipolar disorder may receive an absolute discharge sooner than an accused requiring a longer stabilization period.

Another study conducted in British Columbia on the effects of Bill C-30 pre-*Winko* examined whether NCR accused persons were spending more time in a forensic facility as opposed to the time they would have spent incarcerated in a correctional facility (Vincent, 1999). In addition, factors such as index offence and diagnosis were examined in order to determine whether they were predictive in cases where an accused received an absolute discharge. Results indicated that NCR accused persons tended to serve longer dispositions than convicted offenders in the correctional system. In addition, in cases where absolute discharges were granted, this study found that the most strongly predictive factors were the severity of the index offence and the results of actuarial risk assessments. These findings suggest a considerable reliance upon actuarial risk assessments to determine levels of risk, and also a reliance on the recommendations put forth to the Board by the treatment team.

**B.C. Review Board Statistics (Post-*Winko*)**

Each year, the province of British Columbia (B.C.) releases statistical surveys and various data regarding mentally disordered offenders in the forensic system. This data provides a greater understanding of case management and how it has changed within the province of B.C. before and after *Winko*. 
A statistical report prepared by the B.C. Review Board in April 2002 examined the forensic caseload and provided a chronological history of cases in B.C.'s system over that decade. Although the report focused more closely on cases between April 1, 2002-March 31, 2003, it did provide a basic overview of cases pre and post-Winko. For example, there were 385 cases in B.C. prior to Winko in 1997-1998. Of those 385 cases, 81 were removed from the system that year, which equates to approximately 21%. The year that the Winko case went to court (1998-1999), there were 407 forensic cases. Of that total, 87 were removed by the year's end. This equates to approximately 21%, the same as pre-Winko. Immediately following Winko (1999-2000), there was a marked increase in the cases removed. Of the 442 total cases in the system that year, 114 were removed - approximately 25% of the total, representing an increase of 4%. However, the number of active cases that year was also higher, so one might expect that the case fluctuation would be higher as well. In addition, data provided in this statistical report did not indicate the percentage of absolute discharges in the total number of cases removed. As a result, there was no true reflection of the rates of absolute discharges; however, the document does provide some insight into the movement of cases within the system (British Columbia Review Board Statistical Report, 2003).

Although the B.C. report from April 1, 2002-March 31, 2003 offered a more comprehensive synopsis of case movement during that particular year, it only provided limited insight into other case years. Specifically, the report indicated that there were 56 absolute discharges out of a total of 388 cases in the forensic system that year. In other words, approximately 14% of all of the cases in the system during 2002 and 2003 resulted in an absolute discharge. Of the 34 NGRI (not guilty by reason of insanity)
accused still active in the system that year, only three cases were removed over a span of ten years (British Columbia Review Board Statistical Report, 2003). This low number suggests that these persons will continue to remain a significant threat for quite some time. See Tables 3.1 and 3.2 for a breakdown of case activity.

<table>
<thead>
<tr>
<th>Table 3.1</th>
<th>B.C. Review Board Cases 2002-2003</th>
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<tbody>
<tr>
<td>Status of the Accused</td>
<td>Cases at the Beginning of the Year</td>
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<tr>
<td>NGRI</td>
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<tr>
<td>NCRMD</td>
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<tr>
<td>Fitness</td>
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<td>Total</td>
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<tr>
<th>Table 3.2</th>
<th>B.C. Review Board Dispositions/Outcomes 2002-2003</th>
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<tbody>
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<td>Absolute Discharges</td>
<td>56</td>
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<tr>
<td>Deceased</td>
<td>3</td>
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<tr>
<td>Fitness Finding</td>
<td>19</td>
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<tr>
<td>Interprovincial Transfer</td>
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</tr>
<tr>
<td>Charges Stayed</td>
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</tr>
<tr>
<td>Total</td>
<td>82</td>
</tr>
</tbody>
</table>

**Decision-Making and Mental Health Tribunals**

Jill Peay's (1981) research regarding mental health review tribunals in England and Wales provides some excellent insight into the decision-making process of those bodies. In a study conducted between 1976 and 1980, Peay focused on the "interpretation and application of mental health legislation by individual tribunal members and the manner in which these individual approaches are qualified in the group..."
context” (Peay, 1981: 161). Peay incorporated a questionnaire, a statistical analysis of written board decisions, and also examined the decision-making of the tribunal through a simulated videotape of a mock case. The results of the interviews indicated that, when considered as a group,

the medical members generally had more innovative and enlightened views with regard to stereotypes about mental disorders, the mentally abnormal offender, and treatment under secure conditions. The non-medical members were significantly more likely to conceptualize the mentally disordered as dangerous, impulsive, showing little insight, and as having disabilities of a relatively permanent nature (Peay, 1981: 170).

This is an important finding, as it suggests a noteworthy divide between clinical and non-clinical members of the tribunals. Such differences in opinion may potentially change the dynamic of a tribunal in terms of the decision-making process. Specifically, tribunal members with non-medical experience might not favour the discharge of an accused from a psychiatric hospital into the community - whether it be conditional or absolute (Peay, 1981).

Another important finding in Peay’s research was the manner in which the term ‘dangerous’ was interpreted by members of the tribunal. Although each interviewed member was confident in his or her interpretation of the term ‘dangerous behaviour’, Peay found inconsistent definitions were being used by the various medical, legal, and lay members. She found that non-medical members of the tribunal expressed solid confidence in the opinions of the medical members and their ability to predict dangerous behaviour in an accused. This same confidence was not reciprocated by the medical members themselves, however all interviewees “emphasized the independent medical evidence in preference to the interview with the patient” (Peay, 1981: 171). This further demonstrates the strong reliance of medical-model approaches in their decision-making.
Peay also asked members of the tribunal a series of questions pertaining to how they viewed their role as decision-makers. Results indicated that the majority of respondents asserted that the tribunal had a dual role: 1) to protect public safety, and 2) to protect the liberty of the accused. Specifically, members tended not to view themselves as having the role of a judicial body, “but rather as an informal reviewing panel intended to assess the most appropriate course of action, taking into consideration their conception of the patients ‘best interests’” (Peay, 1981: 171). When asked about their understanding of specific powers available to them as a member of the tribunal under s. 123 of the Mental Health Act, only 29% of members interviewed were cognizant of legislative powers available in terms of discharging a patient. In addition, Peay found that of all the legal members interviewed, less than half were able to provide the correct information regarding their legal options or obligations within the Mental Health Act. Furthermore, Peay concluded that, when taking into account the number of members who were not aware of their permissive powers, there was potentially a one-in-three chance that accused persons would present themselves before the tribunal consisting of members who were all unaware of the discretionary powers set out in the Act (Peay, 1981). This finding is startling, as it suggests that an accused person may unfairly stand in front of a

39 Established in 1959, Section 123 of the Mental Health Act, which governs tribunal decisions states: Where application is made to a Mental Health Review Tribunal by or in respect of a patient who is liable to be detained under this Act, the tribunal may in any case direct that the patient be discharged, and shall so direct if they are satisfied:
(a) that he is not then suffering from mental illness, psychopathic disorder, subnormality or severe subnormality; or
(b) that it is not necessary in the interests of the patient’s health or safety or for the protection of other persons that the patient should continue to be liable to be detained; or
(c) in the case of an application under subsection (3) of section 44 or subsection (3) of section 48 of this Act, that the patient, if released, would not be likely to act in a manner dangerous to other persons or to himself (Peay, 1981: 162-163).
tribunal and receive a disposition that does not accurately reflect the full range of options available to the Board.

Ultimately, Peay found that there was a severe discrepancy between members of the tribunal - specifically, that members were not effectively communicating with one another regarding their decision-making. Upon further examination and reflection, Peay found that there was no evidence to suggest that legal members of the tribunal were more accurately informed regarding the legal issues surrounding mental health legislation than the other members of the group. As a result, Peay deduced that the tribunal did not “appear to be either an effective self-educating process or an effective basis on which to take informed decisions” (Peay, 1981: 174).

Peay also conducted semi-structured interviews with several accused persons, observed tribunal hearings, and analyzed case records. Peay indicated that several patients interviewed were displeased by statements made by their treating doctors: specifically, patients were concerned that statements written in their files were erroneous and that the errors adversely affected the outcome of their hearings. There was also dissatisfaction among patients with respect to interactions with their Responsible Medical Officers (RMO’s) 40. Peay recognized the unease which patients felt in this respect since she found that, in 84% of decisions, the tribunal acted in accordance with the recommendations put forward by the RMO’s. More specifically, RMO’s tended to err on the side of caution and recommend that their patients remained in custody. Such a high percentage of agreement between Mental Health Review Tribunals (MHRT’s) and

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40 RMO’s are legally responsible for a patient and are considered to be the consulting psychiatrist. Their powers, in addition to those of the MHRT’s are legally defined in the 1983 Mental Health Act.
RMO’s prompted Peay to further question whether the tribunals were fully exercising the discretionary discharge powers available to them under the Act (Peay, 1981).

As a result of her extensive research, Peay put forth several insightful conclusions and policy recommendations. Notably, she highlighted the considerable differences in definitions and knowledge between members of the tribunal, particularly in relation to discharge planning. Further, Peay noted that in a large percentage of cases, these differences among members ultimately affected the outcome of the hearings. For example, members with strong or extreme opinions, or those with backgrounds in law or medicine, were more likely to influence the outcome of hearings. Additionally, Peay noted that, as a result of this influence, members of the tribunal were employing subjective decision-making, rather than basing their decisions on objective case facts. However, Peay explained this outcome as a result of the expectations of the system, and not because of the ability of any of the members (Peay, 1981). Although Peay’s findings are not necessarily applicable to the decision-making processes by Canadian Review Board today, none of Peay’s policy proposals were developed any further. Subsequently, no additional research was conducted with regards to her findings for more than a decade (Ferencz & McGuire, 2000).

Therapeutic Decision-Making

Based on concerns previously raised by Peay’s research, an exploratory study was conducted by Ferencz & McGuire (2000), incorporating a qualitative and quantitative analysis of one-on-one interviews with patients detained in hospital and Mental Health Review Tribunal members (MHRT’s) in England. When patients were asked to reflect on their experiences with the tribunal, two themes emerged: 1) their general reaction to
being detained, and 2) their reaction to the tribunal experience (Ferencz & McGuire, 2000). Patients claimed that, while under the jurisdiction of the forensic system, they often experienced what Ferencz and McGuire refer to as “a cycle of distress”. See Figure 3.1 below.

**Figure 3.1. The Cycle of Distress**

![Diagram of Cycle of Distress]

Ferencz & McGuire’s study (2000) found that this cycle of distress provided practitioners with a greater understanding of the concerns of patients and “provided critical insights for improving outcomes for patients through improved tribunal procedures” (50).

Many of the patients interviewed also expressed difficulty communicating with their medical team and with the tribunal. For example, one of the patients stated, “yes you can get confused at a tribunal because they speak amongst themselves. It is like a trial really”. Another patient stated, “they’re so old, I felt like I was at school…they were quite out of touch” (51). Further evidence of this response was brought to light by

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41 From Ferencz & McGuire, 2000, reprinted by permission.
several tribunal members who noted that, in some instances, they were not certain that the patient fully comprehended the proceedings at the hearing. Additionally, members identified particular problems such as "a dislike of specific hearings and of how independent reports were used, the need for further training, the wish for feedback concerning patients' subsequent progress, and difficulties with RMO's", specifically the lack of communication and contact with them (51).

Overall, Ferencz & McGuire (2000) discovered numerous discrepancies between the ways in which patients and MHRT members viewed the tribunal process. Other studies have produced similar results: for example, patients have indicated that they do not feel as though they have been given a voice during hearings and thought that the proceedings lacked fairness (Susman, 1994; Greer, 1996). In terms of seeking a therapeutic approach to decision-making, these concerns raised by patients prove to be invaluable, as they demonstrate the possibly anti-therapeutic consequences that may occur during a decision-making process. According to Wexler and Winick (1992, decisions made by specialized tribunals should be scrutinized to determine whether the outcomes are anti-therapeutic in nature. As such, Ferencz & McGuire suggest that more research should be conducted in the field to further ascertain how tribunals operate and come to their decisions.

Risk and Dangerousness

It has been asserted that "the line between badness and madness is undergoing a constant process of redefinition" (Blumenthal & Lavender, 2000: 4). In light of this phenomenon, it is important to recognize that, regardless of whether an individual is deemed 'bad' or 'mad', there is an element of risk that must be determined. Within the
forensic system, this ‘risk’ can be determined two ways. The first is by means of an individualized clinical risk assessment, which is conducted by a psychiatrist and the hospital treatment team. The results of this particular assessment are determined by collecting relevant data about the progress of the accused and giving recommendations to the Board. The second method of assessment may be achieved through an actuarial risk assessment. This form of assessment resembles a checklist, is standardized to determine a level of risk posed by an offender or an accused, and poses a heavy reliance on static or unchangeable risk factors. Although both methods have been designed to establish a level of ‘risk’, and both methods can be used simultaneously, the process of determining this can be quite different depending on which tool is used.

The Function of Risk Assessments

Risk assessments have two objectives. The first is to recognize individuals who are likely to engage in future violent or dangerous behaviour, and the second is to “identify those factors that can be successfully addressed to minimize future risk through treatment interventions or management strategies” (Moran et al., 2001: 424). Risk factors that examine ‘dangerous’ behaviours can be classified further into static and dynamic factors. Static factors are those that remain fixed such as history of abuse or neglect, previous offences/convictions, and alcohol and drug abuse. Dynamic factors, on the other hand, are changeable, such as affiliation with social groups and current alcohol or drug abuse (Ward & Eccleston, 2000).

Researchers have often used static factors such as criminal and background history in order to predict recidivism for violent offences. Although the accuracy in prediction is relatively small, static factors are still widely used by many clinicians as a
means to further understand the risk that the offender may pose. It has been estimated that only 20-30% of the variance in recidivism can be attributed to static factors (Ward & Eccleston, 2000). Static factors have often been criticized in risk assessments because they take into account factors over which the accused no longer has control. Recent research indicates that examining dynamic factors - in addition to demographic factors (e.g. community support and living conditions) - may be a more reliable method of determining whether an individual poses a risk of re-offending because these are the factors that can realistically be managed in the present and in the future (Monson et al., 2001).

The HCR-20

Of the various methods of assessing risk, practitioners in forensic psychiatric hospital settings tend to use the HCR-20, a violence risk-assessment scheme. This method takes into account historical, clinical and risk-management factors (Grann, Belfrage & Tengström, 2000). Risk-management factors are measured in the HCR-20 by examining certain concerns that may be relevant for the accused, such as intended place of residence and predicted levels of community support available.

Each item on the HCR-20 is scored by either receiving a zero, one or a two. If an accused receives a zero there is no evidence that they have exhibited signs which suggest the presence of that particular item. If they score a one, this means there is some information available to suggest that the particular item exists in relation to the accused. Finally, if a two is scored, it indicates that there is sufficient information provided to demonstrate that the accused possesses the trait or circumstance concerned (Grann, Belfrage & Tengström, 2000). This form of assessment has been criticized because of its
vagueness in determining whether an accused possesses these particular traits (2000). It may be easy to determine definitively if an accused scores a zero or a two on the assessment; however, the score of ‘one’, which states that ‘there is information to suggest,’ is highly subjective and is, therefore, the subject of considerable debate.

The START

The START (Short-Term Risk Assessment of Risk and Treatability) is a new risk assessment tool that has recently been developed for use. It was conceived in Canada and was greatly influenced by the HCR-20. Prior to the START, the majority of previous clinical tools “were developed with the primary intention of protecting the general public, or specific victims from potentially assaulting clients, or informing legal decision-making” (Webster et al., 2004: 2). Additionally, these risk assessment tools typically focused on long-term risk and did not examine the potential for acute and/or short-term violence. Also, most risk assessments have failed to look at any strengths the client may possess and instead have tended to focus primarily on the risks or liabilities posed (Webster et al., 2004). The START; however, aims at addressing these caveats.

The purpose of the START is “to provide mental health professionals with a structured approach which will help organize mental health status evaluations, plan treatments, and communicate risk-related information accurately and consistently” (Webster et al., 2004: 4). In particular, the START expects to inform decision-makers (such as Review Board members) about certain risk factors such as self-harm, suicide, unauthorized leaves, substance abuse, self-neglect, risk of violence to others, and the risk of victimization. However, it is important to note that Winko (1999) states that the “conduct or activity creating the harm must be criminal in nature” (Winko v. British
Columbia, 1999: para. 57). In other words, prior suicide attempts or even current self-harming behaviours cannot legally be presented as ‘risk’ factors. Those behaviours can only be used to aid the treatment team and Review Board in determining a general view of the mental stability of the accused and to assist the treatment staff in avoiding potentially violent incidents.

In addition to examining the risks posed by the accused, the START also takes into consideration their strengths and assets. All factors examined in the assessment are to be viewed in the short-term as it is meant to be administered frequently, even every few weeks or months, depending on the stability of the accused. As is the case with the HCR-20, the START incorporates 20 factors but also includes case specific items that may be pertinent to the accused in question. The START also examines signature risk signs, specific risk estimates (such as self harm or suicide), current management measures, community access, and any health concerns.

Similar to the HCR-20, each of the initial 20 items can be scored by a zero, one or a two. What is unique about the scoring system, however, is that, for these same 20 items, the client is also scored a zero, one or a two for their strength on that factor. For example, for the factor ‘insight’, a client may score a ‘two’ for risk in that they do not believe that they possess a mental illness, but may also score a ‘two’ for strength because they admit that they cannot cope alone and need to be in an assisted-living situation or boarding home.

**Critical Perspectives**

Several studies have been conducted to examine the validity of risk assessments. Owing to the infancy of the START, there is only one evaluative study published. The
study examined the utility of the START by examining accused persons at risk for violence, self-harm, suicide, and unauthorized absences. Preliminary results indicated that the START may be a valid method of assessing and monitoring forensic patients. Further, it was found that in terms of reliability, the START was “generally consistent with similar measures also intended to structure clinical decision making, such as the HCR-20” (Nicholls et al., 2006: 320). However, the study was only performed on patients in the Forensic Psychiatric Hospital in Port Coquitlam, B.C. and those patients were not interviewed. Thus, generalizability is limited. Lastly, inter-rater reliability may have been inflated as it was only the attending mental health professionals within the hospital who completed the START, and other interdisciplinary professionals may have completed the assessment tool in a different manner (Nicholls et al., 2006).

Notably, in 1981, Monahan stated that historical factors were the best predictors of future violence (Glancy & Chaimowitz, 2005). In a more recent Canadian study, however, it was found that historical factors, such as past offences, were less predictive of recurring violence than clinical factors, such as the mental disorder of the accused. Furthermore, “the risk management factors were the ones most strongly associated with violence” (Grann, Belfrage & Tengström, 2000: 100). However, while clinical factors have been found to be more predictive than historical factors, risk-management factors appear to be the most important variables to examine when attempting to predict the future violence of an offender. This finding has major implications for clinicians and Review Boards, as it indicates that an over-emphasis on the historical or clinical factors

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42 It is interesting to note; however, that self-harm and suicidal behaviours are not relevant in the Review Board’s determination of risk as per s. 672.5 of the Criminal Code. This was clarified in Winko (1999), as it was stated that the “harm must be criminal in nature” (Winko v. Winko v. British Columbia (Forensic Psychiatric Institute, 1999: para. 57).
may cause an over-classification or over-estimation in the risk of the accused.

Consequently, Review Boards should focus on how to manage the individual’s potential risk within the community.

As aforementioned, it is a limitation to employ a method where many of the factors examined are static and cannot be altered because it can cause an increase in the number of ‘risky’ diagnoses. For example, an abusive background and the number of previous offences committed cannot be changed, thus an accused may already have an elevated score based on these factors alone. Other studies, however, have found the opposite. Callahan & Silver (1998) and Tellefsen, Cohen, Silver & Dougherty (1992) found that static factors, such as criminal history, were more predictive than dynamic factors, such as clinical attributes and community support. This static/dynamic dichotomy may lead to some confusion as to what variables are more important to take into account.

Not only are there discrepancies between actuarial tools, but there is also some discrepancy between clinicians’ judgments as to whether or not an accused person constitutes a significant threat based on that individual’s risk assessment. Some studies have found that clinicians’ predictions are not significantly related to recidivism as they were “reported to be only marginally better than chance, except in the prediction of non-violent re-offending” (Ward & Eccleston, 2000: 54). While it is the Board members’ responsibility to ensure that the accused no longer poses a threat to the safety of the public when released on an absolute discharge, it may be difficult for them to do so because of potential disagreements between clinicians. With little agreement between clinicians, the Board may frequently choose to err on the side of caution and deny a
request for an absolute discharge. Ward & Eccleston (2000) argue that it would be safer to generate a false positive and continue to keep a non-dangerous accused under the Board’s jurisdiction than to a false generate negative and permit a dangerous individual to be absolutely discharged into the community. In Winko (1999), it was argued that it was not morally acceptable to detain NCR accused persons for fear that they may re-offend unless there was proof that they posed a significant threat to the safety of the public: however in practice, it may be extremely difficult for the Board to make this determination.

Clinicians hold varying opinions regarding the appropriate clinical method of assessment and they also frequently differ in their interpretation of what constitutes ‘dangerous’ behaviour (Ward & Eccleston, 2000). For example, clinicians may compare an accused to another similar case and thus draw conclusions of dangerousness based on that previous case. This method of decision-making is called ‘conditional probability’ and refers to the possibility of an event occurring based on a similar event that has occurred in the past. In a study that examined mental health professionals’ understanding of risk and probability, it was found that the majority of the respondents were unable to correctly answer mathematical questions based on probability. Based on the results of this particular study, it was contended that “no matter how good the data input are, a clinical risk assessment process can have no meaningful output if the conceptual processes underlying decision making is flawed” (Gale, Hawley & Sivakumaran, 2003: 426). Given that the questions asked in this particular study did not address situations of conditional probability but were raising general issues of mathematical probability, it
could be argued that a true understanding of conditional probability and realistic risk assessments would be even weaker (Gale, Hawley & Sivakumaran, 2003).

Grann, Belfrage & Tengström (2000) found that actuarial scales “had higher predictive power among the personality-disordered offenders than among the offenders with schizophrenia” (108). Given that personality disorders\(^{43}\) fall under Axis II diagnoses, should actuarial risk assessments be used at all on individuals who suffer only from an Axis I disorder such as schizophrenia\(^{44}\)? In practice, it is not uncommon for clinicians to avoid using standardized actuarial risk assessment tools and to perform their own individual risk assessment instead. However, this is not to say that standardized actuarial tools are not an appropriate means of determining some level of risk. Both actuarial and clinical methods can be useful, if used in conjunction, when determining the risk of future acts of violence. This is especially pertinent in light of the fact that there are differing views as to which variables are most important to examine when determining risk. In fact, it is common for Review Boards to take into consideration the evidence that has emerged from both clinical and actuarial assessments (Webster, Hucker & Bloom, 2002).

Several researchers have contended that, if clinicians are to use a form of standardized risk assessment, then certain criteria should be met because “the responsible use of such instruments remains a major issue” (Petrila, 2004: 10). For example, Webster, Hucker and Bloom (2002) argue that: (1) the risk assessment should be legally relevant to the case of the accused; (2) the assessment should be evidence-based; (3) the ‘individual’ portion of the assessment should be as specific as possible to the case of the

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\(^{43}\) See note 4 for a detailed explanation of personality disorders.

\(^{44}\) See note 2 for a detailed explanation of schizophrenia.
accused; (4) recommendations should be made toward the Board in order to reduce the level of risk posed by the accused; and (5) that the assessment should include some reference to previous studies that have examined predictive statistical measures of risk and recidivism. The latter requirement has been deemed to be less important than the other four factors. First, it is often difficult to find statistical information that pertains specifically to the exact case at hand, as each person’s case is unique. Moreover, although predictive risk factors may be valuable in determining future violent behaviour or recidivism, they also have limited statistical power. This means that, while certain factors, such as having an abusive background, may be identified as having a potential negative influence on the accused, it does not mean that one is able to predict the exact triggers of violence. In addition, all statistical relevance derived from actuarial risk assessments, which is presented to the Review Boards, must be presented and interpreted very carefully in order for the Board to be aware of the limitations to the tools (Webster, Hucker & Bloom, 2002).

Risk Factors

Research has indicated that the most successful low-risk NCR accused candidate residing in the community tends to be Caucasian, with no criminal history other than the index offence (Monson et. al., 2001). Subsequently, individuals who suffer from co-morbid disorders, such as alcohol or drug use combined with a mental illness or a
personality disorder,\textsuperscript{45} tend to be the most common candidates for relapse, re-
hospitalization and violent behaviours (Monson et al., 2001). A patient suffering from an
Axis II disorder (e.g. a personality disorder) may still be held under the Board’s
jurisdiction if there is a threat that the individual may relapse and, therefore, constitute a
greater risk to re-offend. In this case, even when an accused person no longer shows
signs of their primary Axis I diagnosis (clinical disorder), the manifestation of signs of
dangerous behaviour may jeopardize this individual’s chances of receiving an absolute
discharge (Monson et al, 2001; see Regina v. Wodajo, 2005).

Interpreting Harm and Risk: A Selection of Case Examples

Studying and measuring legal change can be difficult since it is not easy to
develop quantitative measures for the analysis of what are essentially qualitative
decisions. These decisions are designed to be objective; however, ultimately they may be
influenced by subjective determinations. How is one expected to measure how tribunals
come to their decisions? When examining how the Board interprets ‘significant threat’,
one must attempt to understand the differences between the severity of threat posed. For
example, how does the Board interpret miniscule risk, grave harm or trivial harm? These
terms were articulated in Winko (1999) with a view to enabling the Board to differentiate
between the types of threat which the accused may pose in terms of harm to other
persons. For example, miniscule risk may be interpreted in such a manner that an

\textsuperscript{45} It is important to note that, although a personality disorder is classified as a mental illness in the
Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), it cannot be used as a “stand-alone”
defence in a court of law. For this reason, the author has separated personality disorders from other forms
of mental illness allowable in court as a defence. However, it must also be noted that simply because an
accused person has been diagnosed with a mental illness (s)he may still not be eligible for the NCRMD
defence, as it is more the effect of the disorder that becomes the critical issue.
-See note 4 for a definition of personality disorders.
accused may have posed a risk at the time of their index offence; however, the likelihood of that circumstance reoccurring again in the future is very small. The Campagna case (1999) demonstrates an example of what would seem to be a ‘miniscule harm’. In this case, the accused was taking an over-the-counter hunger depressant called Xenedrine in order to become fit and lose weight for a marathon race. The subsequent withdrawal of the medication induced a psychotic state in the accused and she subsequently drove into the back end of another car at high speed and killed the passengers of the vehicle. The accused was granted an absolute discharge from the courts as the likelihood of her being a risk to anyone else in the future was abated (R. v. Campagna, 1999).

In Chambers v. British Columbia (Attorney General) (1997), the B.C. Court of Appeal stated that a small risk of trivial harm is not sufficient to keep an accused under the jurisdiction of the Board. Furthermore, Winko (1999) stated that “there must be a real risk of physical or psychological harm occurring to individuals in the community and in the sense that their potential harm must be serious” (para. 57). This leaves the Board to examine the possibility of either grave harm or trivial harm. However, it is interesting to note that there is no court determination concerning the differences between grave and trivial harm. It is, therefore, left to the Board’s discretion to establish the disparity between the two and apply their interpretations accordingly. This may pose a dilemma, as each member of the Board may have a differing view as to what the two terms mean. This is especially true when comparing the views of a legal member with those of a clinical member of the Board.

R. v. Russell (2004) is another excellent example of a forensic case which raised questions concerning the determination and interpretation of pertinent differences
between the various levels of risk posed. In this case, the accused was found not criminally responsible on account of mental disorder on two counts of assault causing bodily harm in 1996. She had assaulted a health-care worker and another staff member at the Forensic Psychiatric Hospital (previously the Forensic Psychiatric Institute). Ms. Russell was also HIV-positive, which exacerbated the concern regarding injuries sustained by the staff. Although Russell’s mental health and criminal history began in the 1970’s, she had not engaged in any other violent acts since her index offence in 1996. In addition to being HIV-positive, Russell was diagnosed with a schizoaffective disorder\textsuperscript{46}, and had a history of cocaine, cannabis and heroine abuse (\textit{R. v. Russell}, 2004).

The issue in this case was whether Russell represented a significant threat to the safety of the public. As clarified by the majority in \textit{Winko} (1999), “the conduct or activity creating the harm must be criminal in nature” (para. 57). Given that she had not committed an assaultive act since her index offence, the British Columbia Review Board came to the conclusion that she did not pose a significant threat in \textit{that} capacity. What was more difficult to ascertain, however, was whether the fact that she was HIV-positive constituted a ‘significant threat to the safety of the public’. As Justice McLachlin stated, “the commission of an offence in the past may in some circumstances constitute a link in a chain of events that demonstrates a propensity to commit harm, albeit unintentionally” (\textit{R. v. Russell}, para. 24, 2004, as stated in \textit{Winko v. British Columbia}, 1999: para. 60). As such, the Review Board was left to determine whether there was in fact a potential for Ms. Russell to remain a threat to public safety.

\textsuperscript{46} The signs of a schizoaffective disorder may include major depressive disorders, manic episodes, or mixed episodes that display signs of schizophrenia as well (Comer, 1998).
Ms. Russell's case is similar to that of *Chambers v. British Columbia* (Attorney General) (1997), given that both index offences were assault, both accused persons were HIV-positive, they occasionally injected cocaine intravenously, and engaged in prostitution. Arguably, when considering what *Winko* (1999) stated about the necessity of the acts being criminal in nature, "if the literal interpretation of the *Chambers* decision is still good law, the fact that Ms. Russell has HIV... is not a sufficient ground for holding that she poses a significant threat to the safety of the public" (*R. v. Russell*, 2004: para. 26). Consequently, Ms. Russell received an absolute discharge: however, this case provides some insight into the difficult nature of decision-making and the various ways in which risk may be interpreted by the Board.

This chapter has provided an overview of not-criminally-responsible accused persons in British Columbia, therapeutic decision-making within tribunals, and how risk is assessed within these specialized populations. The following chapter will set out the theoretical component of the thesis, and describe the methods used to gather and analyze the data.
CHAPTER 4: THEORY AND METHODS

Introduction

This chapter is divided into two sections. This first section explores the conceptual framework underlying Therapeutic Jurisprudence and the link that this framework has to the decision-making processes of a Review Board or mental health tribunal. There is an explanation of how the concept of Therapeutic Jurisprudence emerged as well as how it has acquired practical utility in a variety of social and legal areas—particularly, drug and mental-health courts. The latter part of the chapter outlines the methodological components incorporated in the current study. Specifically, it addresses the research objectives, the research questions posed, the quantitative and qualitative designs, the data collection, and the methods of analysis.

Therapeutic Jurisprudence

The concept of Therapeutic Jurisprudence essentially emerged from the works of David Wexler. According to Wexler (2003), Therapeutic Jurisprudence is a perspective that regards the law as a social force that produces behaviors and consequences. Sometimes these consequences fall within the realm of what we call therapeutic; and other times antitherapeutic consequences are produced. Therapeutic jurisprudence wants us to be aware of this and wants us to see whether the law can be made or applied in a more therapeutic way so long as other values, such as justice and due process can be fully respected (Wexler, 2003:1).

As a frame of reference or paradigm, Therapeutic Jurisprudence (TJ) has critically analyzed specific fields of legislation, such as mental health law, and questioned whether individuals have been further harmed in relevant adjudicative processes, despite the best
attempts of decision makers to heal them. In addition, Therapeutic Jurisprudence
examines the stakeholders involved in the criminal justice process, the laws set in place,
and the legal procedures surrounding those laws. As such, there is a focus on whether the
outcomes that arise from legal decisions are in fact perceived to be therapeutic or anti-
therapeutic for the individual (Slobogin, 1995). The concept of Therapeutic
Jurisprudence has since impacted several other social and legal areas such as the criminal
justice process, sentencing, corrections, sex offender legislation, domestic violence, tort
law, family law etc.

Advocates of Therapeutic Jurisprudence have acknowledged that, for every
decision that is made, there can be a therapeutic or an anti-therapeutic consequence or
outcome. As such, one of the goals of the practitioners of Therapeutic Jurisprudence is to
seek methods that reduce the magnitude of non-therapeutic outcomes in the courts. An
empirical study by Daicoff (1997) asserted that “attorneys disproportionately rely on
analytic, rational thought to make decisions and are not interpersonally sensitive,
meaning not attuned to the emotions, needs, and concerns of other people and are not
concerned with interpersonal issues or harmony” (Casey & Rottman, 2000: 447, as stated
in Daicoff, 1997: 1377). Daicoff concluded that some legal decisions made may result in
non-therapeutic and ineffective outcomes for an offender or an accused. As a result,
Therapeutic Jurisprudence seeks to humanize the law and recognize that there is a
psychological and emotional aspect when dealing with legal matters. As such, it is
important to identify ways in which the legal system and legislation can maximize the
therapeutic outcome of an offender and reduce the anti-therapeutic effects of the process
(Sales & Shuman, 1996).
Mental Health Legislation and Therapeutic Jurisprudence

Traditionally, criticism of mental health legislation has been centred around the protection of the legal rights of the accused. This might be partly due to the anti-psychiatry views and movements in the 60's and 70's, which aimed to shield accused persons from indeterminate detention by governmental authorities (Laing, 1999). Wexler (1992) contends that in terms of the potentially therapeutic value that legislation has to offer, 'mental health' should be put back into mental health law. Specifically, Wexler argues that the law acts as a social force and, as a result, it may produce both therapeutic and anti-therapeutic consequences. He states that "the task of Therapeutic Jurisprudence is to identify - and ultimately to examine empirically - relationships between legal arrangements and therapeutic outcomes" (102). This task in itself is multidisciplinary and involves examining the therapeutic consequences of legal outcomes and decision-making. Supporters of Therapeutic Jurisprudence do not view the paradigm as paternalistic and do not suggest that therapeutic consequences should supersede all other considerations or should attract more state intervention. Rather, they argue that, holding all other things equal, mental health law should be restructured to better achieve therapeutic ideals and encourage autonomy and self-determination in an accused person (Wexler, 1992; Winick, 1994 & 1997).
Therapeutic Alternatives: Drug Treatment and Mental Health Courts

Drug Treatment Courts

Emerging in the late 1980's as an alternative means to incarceration and separately from Therapeutic Jurisprudence, drug-treatment courts\(^{47}\) offered a new approach to offenders struggling with substance-abuse issues (Berman, & Feinblatt, 2003). Commencing in the United States, the courts have spread internationally. Within Canada, there are now six drug-treatment courts. Instead of cycling through the traditional court system, drug-treatment courts provide an alternative venue for offenders not deterred by the consequence of a jail or prison sentence. Essentially, it offers a more therapeutic approach to offenders suffering from substance abuse by incorporating not only a court component, but also a treatment component. Combined, both elements provide a way for offenders to receive help in overcoming their addictions (Simpson, 2001).

Drug-treatment courts are primarily designed to assist non-violent offenders who have been charged with possession or trafficking small amounts of drugs such as crack cocaine or heroin. Ultimately, the goal of the courts is to place offenders in community-based treatment programs, and reduce the ‘revolving-door syndrome’ for offenders with drug-related problems, thus lowering future drug and criminal activity (Simpson, 2001).

There is a special emphasis on youth, Aboriginals, and street workers. Once a candidate is screened and approved by the Crown, they are placed on one of two possible tracks:

**Track 1:** Those who have little or no criminal record and are charged with simple possession are eligible to enter Track 1 prior to entering a plea. If they complete the program, the charge is withdrawn or stayed. Those whose offences normally

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\(^{47}\) The term “Drug Court” is used only within the United States. In Canada, the correct idiom is Drug Treatment Courts.
would be punishable by more than three months' imprisonment are excluded from Track 1.

Track 2: Offenders with more serious records, or who are charged with trafficking, are required to plead guilty to the charges before entering the Drug Treatment Court program. If they complete the program successfully, they receive sentences that do not involve jail time. Track 2 is generally open to people charged with offences that would be punishable by no more than nine months in prison. Previous offences are reviewed, and people are excluded if their histories indicate that they are unlikely to be amenable to supervision (Simpson, 2001: 2-3).

Using the Toronto Drug-Treatment Court as an example, once a participant enters the program, they are referred to the Centre for Addiction and Mental Health. They are supported by a case manager and work towards realistically attainable goals such as education, work, and housing, while working in conjunction with various community agencies for methadone treatment and counselling (National Crime Prevention Strategy, 2004). Regular appearance in court is mandatory in addition to random urinalysis tests. The drug-treatment court team, which consists of the Judge, the Crown, and the treatment providers, meet on a weekly basis to review the case files. These meetings are vital as they establish a sense of consistency and support for the offender (Simpson, 2003).

One of the important aspects of the program is that the offender assumes accountability and ownership for their actions. As it is common to relapse during drug treatment, offenders do not automatically return to jail if they fail to remain abstinent. They are expected to admit to their use of drugs and are permitted to continue with the program as long as their treatment team feels that they are committed to working towards becoming drug-free (Simpson, 2001). If offenders do not attend court dates, or do not admit to using drugs following a positive urinalysis, they may not be permitted to continue. If they did not enter a plea before the program and were on Track 1, they are returned to court. If they were on Track 2 and pled guilty, they are sentenced (2001).
From an anecdotal standpoint, the therapeutic benefits from the program appear to be powerful. One participant of the Toronto Drug-Treatment Court stated:

At first I was just doing it [the program] to stay out of jail. As I became sober, I started to like it- I started to respect myself... Attending the program during the day and giving the urines helped me. Going to court [regularly] got me into a structured life... Hearing the people and the Judge compliment me made me more motivated every day. Just hearing the Judge compliment me made me feel so good about myself... I found that the Drug Treatment Court has really made the real me come back (Simpson, 2001:3).

Since the inception of the Toronto Drug Treatment Court in 1998, there has been evidence to suggest a reduction in substance abuse and a general improvement in the physical and mental wellbeing of participants (National Crime Prevention Strategy, 2004). For example, a progress report completed in March 2000 indicated that, as of December 31st, 1999, 56% of the participants were still in the program. Of those participants, three-quarters had not re-offended. Of those who did re-offend, the majority had committed drug offences and/or a breach of conditions (Simpson, 2001). Although these specialized courts in Canada appear to be effective, further long-term research is necessary. Within the United States; however, evaluative research on drug courts has been performed and have shown that compared to other community-based treatment programs, drug courts have been successful at reducing criminal activity and drug use (Burdon et al., 2001; Wenzel et al., 2003).

Mental-Health Courts

Similar to drug-treatment courts and the revolving-door syndrome, mental health courts emerged as a result of an increased concern for persons who were suffering from mental illnesses and serving unnecessary sentences in jail for crimes related to their
mental disorders (Stefan & Winick, 2005). Essentially, the argument was that "facilitating the offender's access to mental health treatment [was] a more effective response to the underlying problem than criminal conviction and sentence" (507). As such, the first mental-health court opened in 1997 in Broward County, Florida. Since then, the initiative has spread all over North America, with over 80 courts in the United States and two in Canada (Redlich et al., 2005).

Specifically, mental-health courts were designed to more efficiently and therapeutically address the needs of non-violent accused persons deemed mentally ill and still fit to stand trial. Rottman (2000) states that,

specialized courts provide a forum in which adversarial process can be relaxed and problem solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs (Tyuse & Linhorst, 2005: 233, as stated in Rottman, 2000: 23-24).

The court functions in the early stages of the criminal justice process when the accused first appears at a bail hearing. A mental health court worker will meet with the accused person to assess his/her needs and current situation such as where (s)he lives, his/her support, and his/her access to psychiatric services. A diversion plan is then organized in which the treatment needs of the accused are identified and this plan is subsequently presented to the Crown for approval (Community Resource Connections of Toronto, nd). The accused is then connected to services that address mental health issues in the short and long-term and which will ultimately assist him or her to achieve re-integration into the community through appropriate forms of treatment.

48 Within Canada, there are other specialized courts aside from drug and mental health courts- there are youth courts, domestic violence courts, and an Aboriginal court (The Gladue Court). Located in Toronto, the Gladue Court emerged as result of the Supreme Court ruling R. v. Gladue (1999), which ultimately provided an interpretation of s. 718.2 (e) of the Canadian Criminal Code. As such, judges are now required to consider alternative sentencing options other than incarceration, placing particular emphasis on Aboriginal offenders.
There are several benefits associated with the use of mental-health courts. The first is that the program is voluntary and treatment is provided in the least restrictive manner possible. In addition, unlike the formal criminal justice system process, the focus is placed on the individual and not on punishment. This appears to have a more therapeutic outcome than traditional methods. Although there is no single underlying model in the operation of specialized courts, the assumption for the courts is 'supposed' to be that an accused person is not immediately returned to court and punished if they relapse. As relapse is expected during the recovery process, the accused is theoretically to be supported instead (Tyuse & Linhorst, 2005). Given that mental-health courts have only been operating for approximately ten years, however, much research is still required to establish their effectiveness. Determining the effectiveness of court interventions is socially complex, and special attention should be focused on both quantitative and qualitative methods of gathering and analyzing data (Wolff & Pogorzelski, 2005).

Critiques of Specialized Courts

Both drug and mental-health courts have been criticized for a number of reasons. First, these specialized courts can only cater to a limited number of individuals with drug or mental-health issues. For example, an accused who has committed a serious offence such as murder is not eligible for diversion. In addition, the availability of these courts is limited, but expanding (Tyuse & Linhorst, 2005). For instance, in Canada there are only two mental health courts in the entire country- St. John’s, NB and Toronto, ON, however, Vancouver will soon have a community court which will include some elements of a mental-health court (CBC British Columbia, 2006).
Another critique of specialized courts is the lack of access to available resources in the community. Many community services such as beds in detox clinics, specialized services for women or for racial and ethnic minorities etc. are limited or have lengthy waitlists. Waiting for access to necessary services becomes frustrating, can affect treatment goals, and ultimately become anti-therapeutic for the progress of the accused.

Specialized courts have also been criticized for their element of coercion, and what they claim to do, versus what they actually do. Although these courts and programs are meant to be voluntary, an element of coercion certainly exists when an accused is presented with either the option of serving his/her sentence in jail or participating in the program (Seltzer, T., 2005; Tyuse & Linhorst, 2005). Others have argued, however, that “coerced treatment for substance abuse and mental illness produces outcomes as good as or better than those of non-coerced treatment” (Tyuse & Linhorst, 2005: 237, as stated in Farabee, Prendergast & Anglin, 1998; Farabee, Shen & Sanchez, 2002; Lamb et al., 1996; Miller & Flaherty, 2000).

Another concern regarding specialized courts stems from the fear of further stigmatizing the offender. With a special emphasis on mental-health courts, some researchers are apprehensive that, if “services associated with mental health courts are adequately funded, more charges may be filed against people with mental illness to get them services, further criminalizing them”, thus leading to net widening (Tyuse & Linhorst, 2005: 238, as stated in Wilson et al., 2000). Others, on the other hand, some argue that as judges attempt to balance public safety with the legal rights and needs of the accused, mandatory treatment should be a legitimate function of the court (Tyuse & Linhorst, 2005, as stated in Lamb et al., 1996).
Lastly, the methods by which the effectiveness of these courts is gathered, analyzed, and interpreted have been a cause for concern. Researchers state that a more reliable method of data gathering and interpreting is required - one that takes into account concerns about generalizability, the context of the court, legislation (e.g. provincial differences in Canadian provincial courts) funding, how recidivism is measured, long-term consequences to the offenders, reliability of recorded information in reports, assessing differences in environment, population, socioeconomic status, race, and gender etc. (Heerema, 2005; Tyuse & Linhorst, 2005; Wolff & Pogorzelski, 2005). See Figure 4.1 below.

Figure 4.1 Influences on Structure and Process of Mental-Health Courts49

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Therapeutic Jurisprudence and the Role of a Mental-Health Tribunal

Within the concept or paradigm of Therapeutic Jurisprudence, the traditional roles of criminal justice agents become re-defined - the process is no longer adversarial, and instead becomes inquisitorial. As a result, the traditional judicial roles once defined by the criminal justice process change (See Table 4.1).

Table 4.1  The Traditional Process versus the Transformed Therapeutic Approach

<table>
<thead>
<tr>
<th>Traditional Process</th>
<th>Transformed Therapeutic Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dispute resolution</td>
<td>Problem-solving dispute avoidance</td>
</tr>
<tr>
<td>Legal outcome</td>
<td>Therapeutic outcome</td>
</tr>
<tr>
<td>Adversarial process</td>
<td>Collaborative process</td>
</tr>
<tr>
<td>Claim- or case-oriented</td>
<td>People-oriented</td>
</tr>
<tr>
<td>Rights-based</td>
<td>Interest- or needs-based</td>
</tr>
<tr>
<td>Emphasis on adjudication</td>
<td>Emphasis on post-adjudication and alternate dispute resolution</td>
</tr>
<tr>
<td>Interpretation and application of law</td>
<td>Interpretation and application of social science</td>
</tr>
<tr>
<td>Judge as arbiter</td>
<td>Judge as coach</td>
</tr>
<tr>
<td>Backward-looking</td>
<td>Forward-looking</td>
</tr>
<tr>
<td>Precedent-based</td>
<td>Planning-based</td>
</tr>
<tr>
<td>Few participants and stakeholders</td>
<td>Wide range of participants and stakeholders</td>
</tr>
<tr>
<td>Individualistic</td>
<td>Interdependent</td>
</tr>
<tr>
<td>Legalistic</td>
<td>Common-sensical</td>
</tr>
<tr>
<td>Formal</td>
<td>Informal</td>
</tr>
<tr>
<td>Efficient</td>
<td>Effective</td>
</tr>
</tbody>
</table>

Wexler (1995) emphasizes that Therapeutic Jurisprudence is “not so much law reform as practice reform - focusing on how existing law may be applied therapeutically” (Casey & Rottman, 2000: 451, as stated in Wexler, 1995). In the case of a specialized tribunal such as a Review Board, members have the task of balancing public safety with the legal rights of an accused (British Columbia Review Board, 2003b). Although

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Review Boards also recognize the importance of treatment and care for an accused and although Winko (1999) stresses the need for treatment considerations to be critical, “in practice, the rights perspective has been dominant” (Casey & Rottman, 2000: 446). Some contend that tribunals are unable to act impartially and detached, as they are still functioning “as advocates and defenders of the programs and procedures under challenge” (Christean, 2002).

As a Review Board is comprised of diverse members from varying backgrounds, it also seems fitting for there to be a slight tension between the legal and treatment perspectives. From a legal perspective, a judicial chair may be more inclined to view the process from a legalistic approach, whereas a forensic psychiatrist may approach his or her decision-making with a more treatment and risk-based clinical outlook. This tension may generate some interesting and differing views and may be one of the reasons underlying split decisions\(^5\). As there is a need to rely on evidence-based information and expert evidence regarding the risk posed by the release of mentally disordered accused into the community, the divide between the clinical and legal perspectives may stimulate an interesting debate.

**Critiques of Therapeutic Jurisprudence**

Some have argued that the premise of Therapeutic Jurisprudence is unclear, given that the term ‘therapeutic’ has never been formally defined and does not specify the procedures which should be used in order to determine whether an outcome is therapeutic or anti-therapeutic. As a result, Therapeutic Jurisprudence is seriously

\(^5\) The British Columbia Review Board is comprised of three individuals- a judicial chair, a forensic psychologist/psychiatrist and a lay person (typically a social worker or a criminologist). During the decision-making process of a hearing, there is not always a unanimous agreement between the Board members. In this case, a majority vote is required, and the result is a split decision.
deficient as it only refers in vague terms to the use of the social and behavioural sciences. Nevertheless, Wexler (1995) asserts that Therapeutic Jurisprudence “has quite rightly opted not to provide a tight definition of the term, thereby allowing commentators to roam within the intuitive and common sense contours of the concept” (812). Further, Slobogin (1995) asserts that the term ‘therapeutic’ should simply imply something ‘beneficial’. It becomes beneficial insofar as the social and behavioural sciences are harnessed in order to study “the extent to which a legal rule or practice promotes the psychological and physical well-being of the people it affects” (196). It is a theory that emerged from academic analyses of the social sciences. As such, Therapeutic Jurisprudence offers a unique perspective to the field of social sciences and to legal discourse. However, what is ultimately considered to be ‘therapeutic’ is typically socially defined by policy and decision-makers, and not from the philosophy of Therapeutic Jurisprudence. As such, it is only natural to have differing interpretations of its meaning.

Others have contended that Therapeutic Jurisprudence potentially conflicts with normal due process, individual rights, and public safety. Using drug-treatment courts as an example, it can be argued that encouraging an accused person to plead guilty to drug charges in order to be accepted in the program and receive treatment potentially ignores the intended purpose of the *Canadian Charter of Rights and Freedoms*. Although pleading guilty may be therapeutic and beneficial for an accused person, one must first weigh the importance of the therapeutic outcome against his/her legal rights (Edwards, 2005). However, Wexler (1992) argues that Therapeutic Jurisprudence should not trump

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52 Section 7 through 11 of the *Canadian Charter of Rights and Freedoms* outlines the legal rights that any citizen of Canada possesses. Coercing an accused person or compelling a plea under duress violates the legal rights within the *Charter*. 
other alternative considerations. Rather, he suggests that, in order to provide guidance for legal reform, decision-makers need to be sensitive to the potential for the law to have anti-therapeutic consequences. As such, decision-makers should question "whether the law's antitherapeutic consequences can be reduced, and its therapeutic consequences enhanced, without subordinating due process and justice values" (714).

Therapeutic Jurisprudence has also been critiqued from a methodological perspective. Similar to studying the effectiveness of drug and mental health courts, there are methodological flaws in determining the impact of legal policy on an individual in the system. This argument is well acknowledged by supporters of Therapeutic Jurisprudence. For example, it is acknowledged that when studying the effects of a 'law', randomization of subjects with control groups are not possible, thus the true science in 'social science' is missing (Slobogin, 1995). Additionally, the interpretation of results may be biased as a result of differing value judgments. However, it can be argued that these confounding variables occur in any social science study. Ultimately, a combination of empirical quantitative and qualitative research is required. Winick (1997) asserts that although imperfect, social science research can be of enormous help in the resolution of legal problems...decisions- judicial, legislative, and administrative- often need to be made in the face of uncertainty and frequently are made based on available knowledge, however imperfect (196)...if it is legitimate for courts to rely on untested or inconclusively tested social science theory in reaching decisions, then surely it is legitimate for them to rely on social science empirical evidence, even if indeterminate (197, as stated by Monahan & Walker, 1991).

Research Objectives

The purpose of this study was to examine the effects of the Supreme Court of Canada's ruling in the Winko (1999) case on the decision-making process of the British
Columbia Review Board when it is charged with deciding whether or not to grant an absolute discharge to an accused person. Specifically, it was of interest to examine how the Board interpreted and applied the concept of ‘significant threat to the safety of the public’ as required by s. 672.54 (a) of the Canadian Criminal Code. Furthermore, it was of additional importance to examine the frequency of mention of specific factors within written British Columbia Review Board dispositions and to evaluate their potential importance in the determination of risk.

**Research Questions**

1) What have been the effects of the *Winko* case on the decision-making process of British Columbia Review Board?

2) Are certain factors given more weight than others by the British Columbia Review Board in deciding whether to grant an absolute discharge to an accused person?

3) Has there been an increase in the frequency of references made to possible risk factors in the written decisions of the British Columbia Review Board following the decision in *Winko*?

**Procedural Design**

There were two methodological aspects to this exploratory study, the first being a content analysis of pre-existing written B.C. Review Board decisions, and the second being a set of face-to-face interviews\(^5\). Prior to commencing data collection, the researcher obtained ethical permission by the university ethics committee to conduct the study, and followed all ethical requirements outlined by the university.

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\(^5\) Financial sponsorship was provided for this study by the Forensic Psychiatric Services Commission.
Quantitative Content Analysis

The quantitative component in the study was mostly descriptive, as it simply involved the systematic analysis of written content. It was appropriate to use a content analysis as the goal was to [identify, quantify, and analyze] specific words...with the aim of uncovering some underlying thematic or rhetorical pattern (Huckin, 2004: 14). The analysis included; 12 written decisions from years prior to the beginning of the Winko case (1992 to 1998), 12 decisions from the year in which the Winko case was filed and processed (1999), and 12 decisions from the years following the Winko case (2000 to 2004), for a total of 36 cases.

The cases collected included those in which the British Columbia Review Board granted an absolute discharge, conditional disposition, or custodial order to an accused person between 1992 and 2004. Included in the study was a combination of cases in which there was unanimous agreement by the Board, as well as cases in which the Board was split in their decisions. The majority of the cases, however, were unanimous decisions. Fifteen of the 36 cases involved absolute discharges, 17 involved conditional dispositions, and four involved custodial orders. It was hoped that there would not be as many cases involving custodial orders, as the researcher wanted to examine cases where the Board may be considering an absolute discharge. It was considered to be more desirable to obtain cases where the accused persons were already residing in the community under the terms of a conditional disposition, thereby rendering more meaningful the analysis of the issue of whether they posed a ‘significant threat.’ It is
very rare for an accused to receive an absolute discharge directly from the hospital, as the majority of accused are gradually reintegrated into the community.\textsuperscript{54}

Originally, the written decisions were to be selected from an online legal database entitled \textit{LexisNexis Quicklaw}\textsuperscript{55}: however, the researcher quickly found that it was very difficult to obtain cases from 1992-1998. As an alternative research strategy, the researcher was able to contact the Review Board office in Vancouver to acquire a variety of photocopied decisions collected in between 1992-2004. This method of data collection was purposive or convenient as opposed to random; however, given that the research was exploratory in nature, it allowed the researcher to obtain all of the necessary Review Board decisions for the study. The body of written decisions which were selected included cases in which the index offence consisted of at least a charge of assault. As aforementioned, some of the selected cases involved custody orders as opposed to conditional or absolute discharges because it was difficult to obtain decisions made prior to 1999 from the Quicklaw database. Although the cases provided by the Board were sufficient for the purposes of this study, some were high-profile cases or cases that set a precedent. As such, these cases did not represent the ‘norm’, thus limiting the generalizability of the findings.

After the 36 written decisions were collected, a coding sheet was designed by the researcher in order to assist the content analysis. Initially, a total of 52 variables were chosen (see Appendix C for the original list). These variables were used as a guide and were based on previous literature discussing relevant risk factors to consider when

\textsuperscript{54} The \textit{Campagna} case (1999) is a rare example of an accused person being directly granted an absolute discharge from the hospital. Please see Chapter III for an explanation of the case.

\textsuperscript{55} \textit{LexisNexis Quicklaw} is a Canadian online legal database made available to the researcher in her capacity as a student of Criminology. Please see the Quicklaw home page @ http://www.lexisnexis.ca/ql/en/about/about.html.
assessing the levels of risk posed (e.g. Monson et al., 2001; Strand et al., 1998; Ward & Eccleston, 2000; the HCR-20; and the START). For example, if the written decision mentioned whether the accused person possessed ‘insight’ into his/her mental illness, it was checked on the coding sheet, similar to a scoring system. Each time any variable from the original list was mentioned, it was recorded as were any other relevant risk-related factors which were identified during the analysis. After examining all of the decisions, each variable was summed-up to determine a total score, or a total amount of references made. See Table 4.2 for an example of the coding scheme and a few of the variables examined.

Table 4.2 Examples from the Quantitative Coding Scheme

<table>
<thead>
<tr>
<th>Decision</th>
<th>Winko Status</th>
<th>Disposition Received</th>
<th>Insight into Illness</th>
<th>Substance Use</th>
<th>Medication Compliance</th>
<th>Index Offence</th>
<th>Mental Illness and History</th>
</tr>
</thead>
<tbody>
<tr>
<td>#6</td>
<td>During (1999)</td>
<td>Absolute Discharge</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>#14</td>
<td>Pre (1996)</td>
<td>Conditional Discharge</td>
<td>4</td>
<td>11</td>
<td>0</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>#32</td>
<td>Post (2001)</td>
<td>Conditional Discharge</td>
<td>7</td>
<td>14</td>
<td>8</td>
<td>7</td>
<td>21</td>
</tr>
</tbody>
</table>

After analyzing the written decisions, all variables and cases were transferred for analysis to SPSS, a quantitative statistical software program. Once all of the cases were transferred, the original 52 factors were collapsed into categories that were similar to one another in order to gain a larger and more comprehensive sample of data to work with.

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56 The group ‘Mental Illness’ is an example of a group of variables that were collapsed because of their similarity (Mental Illness, Psychopathy, Personality Disorder, Early Maladjustment, Treatability, and Mental Health History.). This made analyzing less complicated and more inclusive.

57 SPSS is a statistical software program used in this thesis to conduct simple statistical analyses based on the data provided.
For example, all factors that included mention of behaviours exhibited while in the hospital (e.g. returns to hospital, being placed in seclusion etc.), were collapsed into one variable entitled ‘Behaviour in Hospital’. A total of 20 variables were created once the original 52 variables were collapsed. During the statistical analysis, the variables ‘dissent’ and ‘victimization’ were removed as they were not relevant to the task of ascertaining or conceptualizing the level of risk posed. See Table 4.3 below for a list of all collapsed variables.

### Table 4.3 Collapsed List of Variables for the Quantitative Content Analysis

<table>
<thead>
<tr>
<th>Variable</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Skills/Attitudes</td>
<td>Comprised of all references made to social skills, attitude, and coping skills</td>
</tr>
<tr>
<td>Mental State</td>
<td>Comprised of all references made to mental and emotional state, stress, and self-care</td>
</tr>
<tr>
<td>Behaviour in Community</td>
<td>Comprised of all references made to conduct, rule adherence, impulsive behaviours, and supervision status</td>
</tr>
<tr>
<td>Substance Use</td>
<td>Comprised of all references made to the use of drugs or alcohol (past and present)</td>
</tr>
<tr>
<td>Insight into Illness</td>
<td>Comprised of all references made to the accused persons’ insight into his/her mental illness</td>
</tr>
<tr>
<td>Medication Compliance</td>
<td>Comprised of all references made to maintaining or resisting medication compliance</td>
</tr>
<tr>
<td>Self-Harming Behaviours</td>
<td>Comprised of all references made to self-harm behaviours, suicide attempts, and self-neglect</td>
</tr>
<tr>
<td>Mental Illness and History</td>
<td>Comprised of all references made to the accused person’s diagnosed major mental illness, psychopathy, personality disorder, early maladjustment problems as a youth, treatability, and his/her general mental health history</td>
</tr>
<tr>
<td>Winko</td>
<td>Comprised of all references made to the Winko case and/or the objectives of the 1999 Supreme Court decision</td>
</tr>
<tr>
<td>Mention of Other Case Law</td>
<td>Comprised of all references made to legal arguments from previous decisions or precedents (e.g. Orlowski)</td>
</tr>
<tr>
<td>Risk Assessments</td>
<td>Comprised of all references made to any mention of formal or standardized methods used to determine ‘risk’</td>
</tr>
<tr>
<td>Length in Forensic System</td>
<td>Comprised of all references made to how long the accused person has been in the forensic system, and how many times the accused has appeared before the Review Board</td>
</tr>
<tr>
<td>Index Offence</td>
<td>Comprised of all references made to the nature of the index offence</td>
</tr>
<tr>
<td>Risk/Threat</td>
<td>Comprised of all references made to protecting public safety, risk posed to others, significant threat, external triggers, weapon use (past and present), previous and current violent behaviours, documented violence displayed as a youth, and criminal history (including criminal charges, convictions, and previous NCRMD’s)</td>
</tr>
<tr>
<td>Behaviour in Hospital</td>
<td>Comprised of all references made to behaviours leading to re-hospitalization, being placed under observation, suspension of privileges, being placed in seclusion, and unauthorized leaves of absence</td>
</tr>
<tr>
<td>Victim Impact</td>
<td>Comprised of all references made to the submission of a victim impact statement</td>
</tr>
<tr>
<td>Statement</td>
<td>Description</td>
</tr>
<tr>
<td>-------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Social Support</td>
<td>Comprised of all references made to social support in the community and personal relationships with a significant other</td>
</tr>
<tr>
<td>Community Involvement</td>
<td>Comprised of all references made to whether the accused person has attained an occupation, engages in recreational activities in the community, whether (s)he has attained material possessions to help better them, and also references made to future plans stated by the accused</td>
</tr>
<tr>
<td>Dissent$^{58}$</td>
<td>All decisions that were not unanimous in their disposition (past or present)</td>
</tr>
<tr>
<td>Victimization$^{59}$</td>
<td>Comprised of all references made to whether the accused has been victimized while in the hospital or community (emotional and/or physical)</td>
</tr>
</tbody>
</table>

The 36 decisions were divided into three periods; 1992-1998, 1999, and 2000-2004 respectively$^{60}$. Frequency distributions were then performed in order to compare variable frequency within the decisions for each period. In addition, averages of how often a particular variable was mentioned within a given document were calculated. For example, each period contained 12 written decisions. Using the variable ‘medication compliance’ as an example, the total count of mentions within a given period (pre, during or post-*Winko*) would be divided by 12 to calculate the average number of times the variable was mentioned within each document. The averages were then compared against each period. Lastly, the variables were then divided into two groups: clinical and legal. Variables considered to be clinical factors were placed into one category, and variables considered to be legal factors were placed in another. The frequencies of how often variables were mentioned within each clinical and legal group were then compared.

$^{58}$ This variable was removed from *SPSS* for statistical analysis as it was not considered a factor in the decision-making process.

$^{59}$ This variable was also removed from *SPSS* for statistical analysis as it was not considered a factor in the decision-making process either.

$^{60}$ Each of the 36 decisions varied in page and word length. In order to compensate for that, the researcher initially chose to co-vary for article length in *SPSS* using the number of words within each decision. This procedure permitted to control for the length of each document, while holding all other variables constant against one another. However, after performing a correlation between the word length within each document and the total number of references found in each document, their relationship was found to be highly correlated (0.835). To make the analysis less complicated and more standardized, for the remainder of the analysis, the researcher co-varied for the number of references instead of the number of words.
The content analysis for this study was considered to be manifest in nature, as manifest content analyses examine physically present and countable data (Huckin, 2004). In addition, although this analysis was intended to be treated quantitatively, a qualitative approach was also helpful. Specifically, quotes from several decisions were chosen to supplement the results obtained by the content analysis of the written decisions. Content analysis, as a method of analyzing data, has been criticized for being 'too surfaced-based' and ignoring social, interpersonal, and rhetorical meaning, thus lacking validity. In addition, it has been criticized for being too subjective during the coding process, thus lacking reliability (Huckin, 2004). However, Huckin (2004) states that writing research is as much about the products of writing as it is about the processes that produce and interpret them, and focusing on the text itself should be something that writing researchers welcome (p. 28).

It has been contended that another advantage of a content analysis is that it yields information that is no less valuable than other research methods. Content analyses may not provide detailed explanations of the meaning of data; however, within research, all techniques involve the need for the analyst’s interpretation at some point. Lastly, content analyses are able to provide simple frequency distributions which are not obtainable using other techniques that study written content (Huckin, 2004).

Face-to-Face Qualitative Interviews

The qualitative component of the study involved face-to-face interviews with British Columbia Review Board members, defence counsel (e.g. members of CLAS-
Community Legal Assistance Society, Crown counsel, hospital-appointed psychiatrists, and hospital-treatment-team members.

Silverman (2000) asserts that "the methods used by qualitative researchers exemplify a common belief that they can provide a 'deeper' understanding of social phenomena than would be obtained purely through quantitative data" (8). In-person, individual interviews were an excellent means of gathering information for this study. It permitted the researcher to hear directly from the respondent and allowed for the data to speak for itself (Strauss & Corbin, 1998). One of the major limitations of face-to-face interviews is that they typically take a long time to conduct and transcribe (Palys, 2003). However, given that this study was only comprised of 12 interviews, the time required was considerably reduced. Another caveat of face-to-face interviews is that, in some circumstances, participants may try to provide responses that appease the researcher, or responses that are more socially appropriate (Palys, 2003). In hopes of minimizing that risk, the researcher emphasized to participants that the research was exploratory and that there were no expectations in relation to any of their responses.

Prior to interviewing, the experimenter attended public review hearings at the Forensic Psychiatric Hospital in Port Coquitlam, and began to meet various Review Board members and legal counsel. Because the participants in the review hearings rotated, it was imperative to be present at a number of hearings. Further to attending the public hearings, the experimenter took notes regarding the process and the relevant information presented in each hearing. Acting as a complete observer, the experimenter

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61 All hospital-appointed psychiatrists and treatment team members are affiliated with the Forensic Psychiatric Hospital, the only forensic hospital in the province of British Columbia. In addition, the legal members interviewed from defence and Crown counsel were all active participants in Review Board hearings on a regular basis.
identified herself as a researcher, while aiming to be as inconspicuous as possible (Palys, 2003). It should be re-stated, however, that review hearings are open to the public and thus, the interviewers' presence should not have altered the context of the setting or made it artificial in any way. Being an observer and gaining an inside knowledge of the setting and the decision-making process assisted the researcher in the formulation of the questions for the interviews.

The interviews commenced in June 2004 and were completed by November 2004. A total of 12 interviewees expressed an interest in participating in the study. After making initial contact with a member of CLAS at a Review Board hearing, the researcher was given contact numbers for other potential participants. An e-mail was also forwarded to the main office of the B.C. Review Board in Vancouver to inquire if any members of the Board were available and would consent to an interview. If an agreement was made to be interviewed, the respondent was given more details regarding the premise of the study and a day and time for the interview were scheduled. Once the researcher met with the participants, they were asked to read and sign a consent form explaining the objectives of the study, including an assurance of confidentiality. Altogether, four lawyers, five Review Board members, and three clinicians consented to an interview.

Approximately one-hour interview sessions with the respondents were conducted either directly following the public review hearings or, alternatively, at a more convenient time. The interview questions were open-ended, as it permitted the interviewee to expand on the questions asked (see Appendix B for interview questions). Open-ended questions were advantageous because it allowed for an opportunity to hear opinions

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62 All interviews were conducted in Vancouver and the lower mainland, aside from one interview that took place in Victoria, British Columbia.
regarding the effects of *Winko* on the interpretation of the phrase, “significant threat”, and important risk factors. The interviews were semi-structured and particular questions were prepared in advance by the researcher. The interviewer asked the respondents a series of questions and informed them that they could skip a question and return to it at a later time, or could skip a question altogether. There was also an opportunity for the participants to return to a question and expand on their answers - in addition to providing any other information they felt relevant. As some of the participants from a clinical or treatment background were not actively sitting on the Board or participating in hearings, there were certain legal questions that could not be answered.

The questions were directly related to the research objectives and aimed to be as straightforward as possible. The research objectives were made clear to each of the respondents, and the open-ended questions provided them with the opportunity to discuss how they felt the *Winko* case affected them professionally or affected the Board’s decision-making process as a whole. The researcher was careful to word the interview questions in such a way as to not cause any ambiguities or lead the respondent in a certain direction (Lasley, 1999). There were seven questions asked in total in order to limit inconveniencing the respondent by a lengthy interview (see Appendix B for the breakdown of subsections within the questions). The researcher obtained consent to use a recording device in eleven of the twelve interviews\(^\text{63}\), and the interviews were later transcribed electronically. All responses were kept strictly confidential and anonymous, and any identifying information will be destroyed after the thesis defence. During the

\(^{63}\) During the one interview that was not tape recorded, the respondent answered the questions at a pace that allowed the researcher to write down his/her responses verbatim.
collection of data, all identifying documents were kept in a separate location from the responses given.

After the interviews were completed, they were transcribed and placed into rich text format so that they could be uploaded into a qualitative software program entitled *QSR NVivo*\(^{64}\). The interviews were subsequently examined for emerging themes.

Drawing from previous research on risk factors and from the results of the content analysis, the various qualitative themes were compared to determine commonalities and disparities.

As this study was approached from a deductive perspective, it was important to combine the quantitative content analysis with the qualitative interviews in order to gain a more comprehensive insight into the decision-making patterns of the Review Board.

Using an application of various methods in a study is referred to as triangulation, and can permit an increase in value and meaning to data. However, using several methods in a study (e.g.: triangulation) has been criticized for attempting to seek an overall truth that may not be possible, thus adopting naïve optimism. It has also been argued that methods such as triangulation may falsely create a complete picture, and falsely increase validity and reliability (Silverman, 2000). For the purposes of this study, the methods of quantitative and qualitative analysis were not used to further solidify the outcome of the data. Instead, they were used to distinguish any parallels and disparities between the findings in the content analysis and those obtained in the interviews. Additionally, as the research was exploratory, the aim was not to generalize or to understand the whole picture, as exploratory research generates no expectations beforehand.

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\(^{64}\) *QSR NVivo* is a qualitative software program that was used to help simplify the thematic coding of the interviews. However, the program was functional only as an organizational tool and not for data analysis.
Chapters 2, 3, and 4 respectively provided a general overview of the legal background, the literature, and the methods directing this study. The next chapter describes both the quantitative and qualitative findings of the research.
CHAPTER 5: FINDINGS

Introduction

The purpose of this study was to examine the effects of the *Winko* case on the decision-making process of the British Columbia Review Board when it is charged with determining whether or not to grant an absolute discharge to an accused person. This chapter commences with an examination of the results produced from a content analysis of 36 written decisions by the B.C. Review Board. Within each decision, the focus was placed on the frequency of specific factors mentioned across three periods; 1992-1998, 1999, and 2000-2004. A qualitative analysis of 12 face-to-face interviews follows. Specifically, discussion centres on seven themes that emerged from the interviews.

Quantitative Content Analysis Findings

Frequency Findings

Using *SPSS*, variables were placed into a frequency distribution to observe how often each category of references appeared in the decisions over the different periods: pre, during, and post-*Winko*. Table and Figure 5.1 demonstrate the frequency of all variables mentioned within the 36 written decisions. Results indicated that the most frequently cited variable in all written decisions was 'risk/threat'. This particular variable contributed to 23.9% of all references made within the 36 documents. As the variable 'risk/threat' was comprised of many collapsed variables, Table 5.2 displays a breakdown of what the variable included. Figure 5.2 provides a visual representation of this...
breakdown. It can be noted that, within the breakdown of this variable, the most commonly mentioned factor was whether an accused posed a ‘significant threat’ to public safety (39.7%).

Referring back to Table 5.1, the second most frequently cited variable within all of the written decisions was ‘substance use’ (10.1%), followed by ‘mental illness and history’ (8.9%), ‘mental state’ (8.3%), ‘medication compliance’ (7.3%), ‘behaviour in community’ (6.5%), and ‘social support’ (5.5%) respectively. References made to the ‘index offence’ of the accused represented 4.9%, while ‘insight into illness’ only constituted 4.0% of all references made. See Table 5.1 below for a list of reference totals for each variable.

Table 5.1 Variable Reference Totals within All Decisions

<table>
<thead>
<tr>
<th>Variable</th>
<th>Number of References</th>
<th>Percentage of Total References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk/Threat</td>
<td>580</td>
<td>23.9%</td>
</tr>
<tr>
<td>Substance Use</td>
<td>246</td>
<td>10.1%</td>
</tr>
<tr>
<td>Mental Illness and History</td>
<td>216</td>
<td>8.9%</td>
</tr>
<tr>
<td>Mental State</td>
<td>201</td>
<td>8.3%</td>
</tr>
<tr>
<td>Medication Compliance</td>
<td>177</td>
<td>7.3%</td>
</tr>
<tr>
<td>Behaviour in Community</td>
<td>157</td>
<td>6.5%</td>
</tr>
<tr>
<td>Social Support</td>
<td>134</td>
<td>5.5%</td>
</tr>
<tr>
<td>Index Offence</td>
<td>119</td>
<td>4.9%</td>
</tr>
<tr>
<td>Insight into Illness</td>
<td>98</td>
<td>4.0%</td>
</tr>
<tr>
<td>Risk Assessments</td>
<td>87</td>
<td>3.6%</td>
</tr>
<tr>
<td>Winko</td>
<td>76</td>
<td>3.1%</td>
</tr>
<tr>
<td>Length in Forensic System</td>
<td>71</td>
<td>2.9%</td>
</tr>
<tr>
<td>Community Involvement</td>
<td>71</td>
<td>2.9%</td>
</tr>
<tr>
<td>Other Law Cases</td>
<td>65</td>
<td>2.7%</td>
</tr>
<tr>
<td>Hospital Behaviour</td>
<td>60</td>
<td>2.5%</td>
</tr>
<tr>
<td>Self-Harming Behaviours</td>
<td>41</td>
<td>1.7%</td>
</tr>
<tr>
<td>Social Skills/Attitudes</td>
<td>24</td>
<td>1.0%</td>
</tr>
<tr>
<td>Victim Impact Statement</td>
<td>3</td>
<td>0.1%</td>
</tr>
</tbody>
</table>
Table 5.2  Variable ‘Risk/Threat’ Frequencies within All Decisions

<table>
<thead>
<tr>
<th>Variable</th>
<th>Number of References</th>
<th>Percentage of Total References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Significant Threat</td>
<td>230</td>
<td>39.7%</td>
</tr>
<tr>
<td>Previous Violence</td>
<td>103</td>
<td>17.8%</td>
</tr>
<tr>
<td>Risk to Others</td>
<td>71</td>
<td>12.2%</td>
</tr>
<tr>
<td>Criminal History</td>
<td>65</td>
<td>11.2%</td>
</tr>
<tr>
<td>Weapon Use</td>
<td>21</td>
<td>3.7%</td>
</tr>
<tr>
<td>External Triggers</td>
<td>17</td>
<td>2.9%</td>
</tr>
<tr>
<td>Youth Record</td>
<td>7</td>
<td>1.2%</td>
</tr>
<tr>
<td></td>
<td>580</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Note: Results from a selection of 36 written decisions.
The frequency with which variables were mentioned within a given period was also calculated. Each variable was broken down into three periods: 1) pre-Winko, 2) during the Winko decision, 3) post-Winko, and analysed to determine if any variable was mentioned more frequently within that given period. Results are visually presented in Table 5.3 and Figure 5.3. Although statistical significance was not established, the findings still demonstrated that the majority of factors mentioned within written decisions increased post-Winko. For example, references made to ‘medication compliance’ were made more than four times as often post-Winko than pre-Winko (4.2). Additionally, references made to ‘social skills/attitudes’ were made six times more often, and references made to ‘insight into illness’ and ‘community involvement’ were made more than twice as often post-Winko (2.4 and 2.3 respectively). The variable ‘social support’
was also mentioned more frequently post-*Winko* (1.6 times more often). The only
variables that decreased in terms of the frequency of mention post-*Winko* were ‘length in
forensic system’, ‘other law cases’, ‘substance use’, and ‘self-harming behaviours’.
Mentions of ‘self-harming behaviours’ accounted for the largest discrepancy pre and
post-*Winko*, as this factor was mentioned ten times more often pre-*Winko*. 
Table 5.3 Reference Totals by Variable by Period

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk/Threat</td>
<td>178</td>
<td>25.2%</td>
<td>14.8</td>
<td>186</td>
<td>24.2%</td>
<td>15.5</td>
<td>216</td>
</tr>
<tr>
<td>Index Offence</td>
<td>25</td>
<td>3.5%</td>
<td>2.1</td>
<td>51</td>
<td>6.6%</td>
<td>4.3</td>
<td>43</td>
</tr>
<tr>
<td>Winko</td>
<td>0</td>
<td>0.0%</td>
<td>0.0</td>
<td>39</td>
<td>5.1%</td>
<td>3.3</td>
<td>37</td>
</tr>
<tr>
<td>Length in Forensic System</td>
<td>27</td>
<td>3.8%</td>
<td>2.3</td>
<td>22</td>
<td>2.9%</td>
<td>1.8</td>
<td>22</td>
</tr>
<tr>
<td>Other Law Cases</td>
<td>34</td>
<td>4.8%</td>
<td>2.8</td>
<td>9</td>
<td>1.2%</td>
<td>0.8</td>
<td>22</td>
</tr>
<tr>
<td>Victim Impact Statement</td>
<td>0</td>
<td>0.0%</td>
<td>0.0</td>
<td>0</td>
<td>0.0%</td>
<td>0.0</td>
<td>3</td>
</tr>
<tr>
<td>Substance Use</td>
<td>108</td>
<td>15.3%</td>
<td>9.0</td>
<td>50</td>
<td>6.5%</td>
<td>4.2</td>
<td>88</td>
</tr>
<tr>
<td>Mental Illness and History</td>
<td>57</td>
<td>8.1%</td>
<td>4.8</td>
<td>76</td>
<td>9.9%</td>
<td>6.3</td>
<td>83</td>
</tr>
<tr>
<td>Mental State</td>
<td>57</td>
<td>8.1%</td>
<td>4.8</td>
<td>76</td>
<td>9.9%</td>
<td>6.3</td>
<td>68</td>
</tr>
<tr>
<td>Medication Compliance</td>
<td>21</td>
<td>3.0%</td>
<td>1.8</td>
<td>66</td>
<td>8.6%</td>
<td>5.5</td>
<td>90</td>
</tr>
<tr>
<td>Behaviour in Community</td>
<td>58</td>
<td>8.2%</td>
<td>4.8</td>
<td>38</td>
<td>4.9%</td>
<td>3.2</td>
<td>61</td>
</tr>
<tr>
<td>Social Support</td>
<td>36</td>
<td>5.1%</td>
<td>3.0</td>
<td>40</td>
<td>5.2%</td>
<td>3.3</td>
<td>58</td>
</tr>
<tr>
<td>Insight into Illness</td>
<td>20</td>
<td>2.8%</td>
<td>1.7</td>
<td>30</td>
<td>3.9%</td>
<td>2.5</td>
<td>48</td>
</tr>
<tr>
<td>Risk Assessments</td>
<td>23</td>
<td>3.3%</td>
<td>1.9</td>
<td>35</td>
<td>4.6%</td>
<td>2.9</td>
<td>29</td>
</tr>
<tr>
<td>Community Involvement</td>
<td>14</td>
<td>2.0%</td>
<td>1.2</td>
<td>24</td>
<td>3.1%</td>
<td>2.0</td>
<td>33</td>
</tr>
<tr>
<td>Behaviour in Hospital</td>
<td>21</td>
<td>3.0%</td>
<td>1.8</td>
<td>5</td>
<td>0.7%</td>
<td>0.4</td>
<td>34</td>
</tr>
<tr>
<td>Self-Harming Behaviours</td>
<td>25</td>
<td>3.5%</td>
<td>2.1</td>
<td>14</td>
<td>1.8%</td>
<td>1.2</td>
<td>2</td>
</tr>
</tbody>
</table>

Please note that the percentage of references fluctuate post-Winko because the actual counts or number of references have increased. More specifically, the number of total references increased post-Winko from 706 to 951.
<table>
<thead>
<tr>
<th>Social Skills/Attitudes</th>
<th>2</th>
<th>0.3%</th>
<th>0.2</th>
<th>8</th>
<th>1.0%</th>
<th>0.7</th>
<th>14</th>
<th>1.5%</th>
<th>1.2</th>
<th>6.0*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Reference Counts</td>
<td>706</td>
<td></td>
<td></td>
<td>769</td>
<td></td>
<td></td>
<td>951</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Results from a selection of 36 written decisions.

* Indicates how many more times a variable was mentioned within a decision post-Winko.

** Indicates how many more times a variable was mentioned within a decision pre-Winko.
Table 5.4 illustrates the breakdown of the variable, 'risk/threat'. Results indicated that the factors 'significant threat', 'previous violence', 'risk to others', 'external triggers', and 'youth record' were all mentioned more frequently post-Winko. Subsequently, 'criminal history' and 'weapon use' were the only two factors mentioned less frequently post-Winko, as mentions of 'weapon use' were more than five times greater pre-Winko (5.4). Overall, the greatest difference between periods was found in relation to 'youth record'. The mention of this variable increased slightly over 6 times post-Winko (6.3), followed by 'significant threat' (1.6), and 'risk to others' (1.5) respectively.
Indicates how many more times a variable was mentioned within a decision post-Winko.

Indicates how many more times a variable was mentioned within a decision pre-Winko.

Table 5.4 Variable ‘Risk/Threat’ Frequencies by Period

<table>
<thead>
<tr>
<th>Variable</th>
<th>Number of References</th>
<th>Pre-Winko</th>
<th>During Winko</th>
<th>Post-Winko</th>
<th>Avg. Mention Post versus Pre-Winko</th>
</tr>
</thead>
<tbody>
<tr>
<td>Significant Threat</td>
<td>230</td>
<td>58</td>
<td>82</td>
<td>90</td>
<td>1.6*</td>
</tr>
<tr>
<td>Previous Violence</td>
<td>103</td>
<td>36</td>
<td>26</td>
<td>41</td>
<td>1.1*</td>
</tr>
<tr>
<td>Risk to Others</td>
<td>71</td>
<td>20</td>
<td>20</td>
<td>31</td>
<td>1.5*</td>
</tr>
<tr>
<td>Criminal History</td>
<td>65</td>
<td>22</td>
<td>22</td>
<td>21</td>
<td>1.1**</td>
</tr>
<tr>
<td>Weapon Use</td>
<td>21</td>
<td>11</td>
<td>8</td>
<td>2</td>
<td>5.4**</td>
</tr>
<tr>
<td>External Triggers</td>
<td>17</td>
<td>5</td>
<td>5</td>
<td>7</td>
<td>1.4*</td>
</tr>
<tr>
<td>Youth Record</td>
<td>7</td>
<td>1</td>
<td>0</td>
<td>6</td>
<td>6.3*</td>
</tr>
<tr>
<td></td>
<td>580</td>
<td>153</td>
<td>163</td>
<td>198</td>
<td></td>
</tr>
</tbody>
</table>

Note: Results from a selection of 36 written decisions.
* Indicates how many more times a variable was mentioned within a decision post-Winko.
** Indicates how many more times a variable was mentioned within a decision pre-Winko.

Lastly, all variables were divided into two groups: clinical versus legal (see Appendix D for the list of collapsed variables). As Table 5.4 demonstrates, the average number of references pre and post-Winko were compared. Within the written decisions, it was found that clinical factors were mentioned more frequently than legal factors both pre and post-Winko. On average, clinical factors post-Winko were referenced a little over 50 times per decision, whereas legal factors were only referenced slightly over 28 times. Thus, within the written decisions, clinical factors were mentioned almost twice as often as legal factors.

Table 5.5 ‘Clinical’ and ‘Legal’ Average Number of References per Decision Pre/Post-Winko

<table>
<thead>
<tr>
<th>Reference Type</th>
<th>Average Per Decision: Pre-Winko</th>
<th>Average Per Decision: Post-Winko</th>
</tr>
</thead>
</table>

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Qualitative Interview Findings

The questions posed during the interviews generated several themes with regards to the impact of *Winko* and how the Board interprets and applies ‘significant threat to the safety of the public’. In total, seven themes will be discussed: 1) the most important issues when assessing significant risk/threat; 2) how respondents interpreted significant threat; 3) the impact of *Winko* on individual risk; 4) focusing on past, present, or future risk; 5) the assessment of risk; 6) split decisions; and 7) important factors to consider.

Theme #1- Most Important Issues when Assessing ‘Significant Risk/Threat’

The majority of the respondents stated that it was difficult to determine what was *most* important when assessing significant risk. One of the respondents stated that, “when you’re talking about significant threat, what it boils down to is public safety versus personal liberty”. This particular statement seemed to resonate throughout all of the other interviews. For all respondents, it was vital to have an “integrated opinion” about various factors that may determine whether an accused posed a risk. For example, it was agreed amongst several respondents that it was important to examine both static and dynamic factors. One particularly interesting sub-theme that emerged from the discussion surrounding static and dynamic risk factors was that of substance abuse. Several respondents indicated that a history of substance and alcohol abuse were both major destabilizing factors. In fact, one respondent stated that “close to 80% of [accused

<table>
<thead>
<tr>
<th>Clinical</th>
<th>36.8</th>
<th>50.7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal</td>
<td>22.0</td>
<td>28.6</td>
</tr>
</tbody>
</table>

Note: Results from a selection of 24 written decisions. The decisions during *Winko* (1999) were not included as the comparison was only necessary between pre and post-*Winko*. 

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persons] have a concurrent disorder (sic) … that is, a mental illness in addition to a substance abuse or addictions problem”. Respondents were of the opinion that drugs and alcohol increased the risk that accused persons posed in the community because it mentally destabilized the accused and thus increased the likelihood that he or she would act out in a violent manner.

**Theme #2 - How Respondents Interpreted ‘Significant Threat’**

When analyzing this theme, a divide between respondents working in the legal field versus those in the clinical field was evident. From a legal perspective, respondents often quoted Winko and the Criminal Code. It was noted by several respondents that Winko attached with it a “reasonably foreseeable risk;” thus “risk, by definition, [had] a future connotation”. It was also stressed that the concept of risk had more of a legal implication as opposed to a clinical one. Although both the terms ‘risk’ and ‘threat’ were often used interchangeably by several respondents throughout the interviews, some respondents articulated a specific and distinct difference between the two terms.

From a clinical perspective, however, the interpretation of significant threat was seemingly different. It was noted by one participant that clinicians often tend to try and predict how patients are going to behave once they are released into the community. It was also stated that, whereas a legal view focuses on “evidence-based information”, clinical views tend to centre on “gut feelings [and] anticipate (sic) things that may happen”. One participant stated that, although (s)he was “trained by Winko, [it is still] a vague concept” and there were “no qualitative scheme to follow, [and] no statistics reliable enough to predict dangerousness”.

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The concept of significant threat was also discussed in relation to criminal behaviour. Many respondents clarified that the determination of significant threat must be in conjunction with a risk of criminal behaviour towards a member of the public. In addition, respondents stated that, in light of *Winko*, physical and psychological harm warranted inclusion in the interpretation of significant threat. It was stated, however, that because *Winko* includes all of these forms of harm, “everybody is a threat of some sort”. As such, it was important to rule out threats that were too remote to justify ongoing jurisdiction.

**Theme #3 - The Impact of *Winko* and Individual Risk**

This particular theme emerged when respondents were asked to state how *Winko* had impacted (if at all) the way in which they evaluated individual risk. As some of the respondents had not been working in the field prior to *Orlowski*, there were few comparisons highlighting the differences between *Orlowski* and *Winko* during the interviews. Some felt that *Winko* has created a more clear understanding of what was already written in the *Criminal Code*, while others felt that *Winko* has not been pragmatically useful in terms of aiding the decision-making process of the Board. For other respondents, more particularly those adopting a clinical perspective, the *Winko* decision had not necessarily affected the manner in which they assess an accused person at all. As one clinician noted that

realistically speaking, I haven’t really seen any pragmatic differences in the decisions that the Board has been making. They certainly refer a lot to *Winko*, but I haven’t actually seen an impact on the Boards...they talk a lot about it, but I don’t know if it’s made any differences in the outcomes.
However, another clinician offered a different viewpoint with regard to the impact of 

*Winko* on individual risk. This clinician stated that "the impact of *Winko* on determining individual risk has...forced the clinician to look at significant risk. It has focused this issue very well", while another respondent stated that

before *Winko* they were everywhere, all over the map in terms of trying to get information on how the patient was [and] what the risk issues were. *Winko* narrowed it down and focused it in terms of what types of questions they asked us at Review Board hearings.

From a legal perspective, respondents generally agreed that *Winko* influenced them to evaluate each case a little more cautiously. However, it was also contended by one respondent that *Winko* was "common sense...a more detailed version of what [was] already in the Criminal Code". One respondent added that, as in the Orlowski case, "...*Winko* expanded the definition of the words significant threat to the safety of the public...with a future connotation". As such, participants had mixed feelings with regard to whether the future connotation worked in favour of an accused person. One respondent stated that "*Winko* has made it a little bit easier for an accused to get discharged:" however, some respondents later alluded to the fact that the future connotation of *Winko* may actually pose more of a challenge for an accused seeking an absolute discharge.

**Theme #4 - Focusing on Past, Present, or Future Risk**

When respondents were asked whether they tended to focus on the past, present, or future risk of an accused, five of the twelve respondents stated that examining both present and future risk factors were of equal importance in determining the level of risk. One respondent stated that
for somebody who has been under our jurisdiction for a number of years but is in no way under close supervision, or a current or immediate significant threat...then the question shifts to yes, he’s not a risk today, but could he be a risk in the future?

Although many respondents admitted that examining past, present, and the likelihood of future behaviours were all important, many also agreed that *Winko* brought with it a particular emphasis on the future and that, as a result, foreseeing potential risks was of great importance to them. From a legal standpoint, this was apparent from statements, such as “we certainly focus on both present and future [but] future is much more important because it is our job to protect the future”, and

I’m more concerned with future risk, which is typically the danger of a person who currently seems safe for the community but may have very concerning factors in his case which forecast a likely decline in mental health, and a corresponding return to dangerous behaviour.

Alternatively, from a clinical standpoint, one of the participants stated that we also have to anticipate what factors could increase their risk. Certainly factors within the hospital are very different from the factors out in the community. So when looking at future risk, it doesn’t necessarily mean that because they are doing well in the hospital that we allow them some increased privileges to go out to the community. We have to ensure and to be aware that if they go out into the community, we’ve put things in place so that the risk is minimal.

**Theme #5 – The Assessment of Risk**

When asked how the risk of an accused was assessed, there was a deliberate emphasis on the part of the researcher to inquire about whether or not the use of formal risk assessments (such as the HCR-20 or the START) were an integral part of that process of determination. Statements indicated that, although risk assessments were frequently used within the forensic system to aid in the determination of risk, they were not the sole measure by means of which risk was ascertained. Several respondents
referred to an integrated approach, combining clinical tools with historical risk factors, in addition to notes compiled by the treatment team. One respondent stated that

[although] we certainly hear a lot about competing risk assessment instruments that are in use, I don’t think that the Board ought to, or a decision-maker ought to, align itself in terms of any acceptance of any one risk assessment instrument over another.

Other statements regarding the use of actuarial risk assessments continued to follow the contention that, although the use of an actuarial tool proves to be useful as a guideline or an organizational tool, a more comprehensive approach is necessary. Additionally, regarding the assessment or prediction of risk in an accused, respondents made comments such as “it is not an exact science”, and stressed that “[an actuarial risk assessment] doesn’t allow or necessarily instruct us how to rate or place the given factors”.

Miniscule Risk

Respondents were asked to offer an example of how they interpreted ‘miniscule risk’ in light of the decision in Winko. The clinicians or treatment team members who were interviewed and who were not familiar with the legal terminology in Winko, preferred not to comment on this portion of the interview. Of those who were familiar with the term miniscule risk, the examples given were very similar in situation and circumstance to one another. Theses examples included scenarios where an individual commits a serious index offence, but the likelihood of ever repeating that offence would be so unlikely that (s)he could not be considered a significant threat. As a result, (s)he would be categorized as posing only a miniscule risk. Other examples offered were situations where an individual may be at a high risk of re-offending, but the harm
committed would be petty and the risk posed to society would be minimal (e.g. a property
offence or a dine-and-dash).

**Grave Harm**

Respondents were also asked to provide their interpretation of the term, 'grave
harm', which was employed in *Winko*. Once more, clinicians did not provide a response
to this portion of the interview if the legal terminology was not familiar to them. For
those who did respond, it appeared that respondents were more easily able to provide
eamples of what they deemed to be a grave harm. The majority of examples relating to
the issue of grave harm included serious offences such as assault causing bodily harm
and/or murder. One respondent added that “one would have to follow *Winko*, that grave
harm includes physical harm in all forms. *Winko* also directed that psychological harm is
as significant, and warrants inclusion”. It was evident that respondents were still looking
to *Winko* as a guide but they were also able to provide concrete examples.

For others, acquiring information as to whether an accused person posed a grave
harm was of the utmost importance. It was stated that even a small risk of grave harm
warranted serious attention on the part of the Board since even a miniscule risk of an
event occurring might result in a grave harm. An example provided was that of a frail
person at risk of becoming ill again. Although they may only be known for occasionally
pushing random strangers, if they push someone near a stairway, it could very easily
escalate to a grave harm.
Trivial Harm

When asked to provide an example of a minuscule risk or a grave harm, respondents were quickly able to provide examples: however, they were not as confident in directly identifying trivial harms. As the Criminal Code does not define what constitutes a trivial harm, the interpretation of that form of harm became more difficult. One respondent stated that determining trivial harm would be the most likely area where disagreement on the Board would occur. Others stated that an example of trivial harm may be where an accused person has breached probation or a peace bond but without any violence. It was stated that generally the Board

[doesn't] see as many of those [cases entering the system] anymore unless the person can’t get help any other way. Then the system seems to think that this is a way of helping them...so they get them, they work on finding them NCRMD so they can get them in the system, and then get them treatment.

It was also stated that threatening another person used to be an example of trivial harm until Winko. It has now changed because there is a psychological component stated in Winko that acknowledges behaviours such as threatening another individual as a psychological harm that may warrant a denial of an absolute discharge, especially if the Board determines that it is an ongoing and/or escalating concern.

Theme #6 – Split Decisions

This theme emerged when respondents were questioned about the process leading up to split decisions. Specifically, the researcher was curious about certain factors related to the genesis of split decisions and some of the circumstances surrounding them. Two clinical factors were mentioned in the context of a divide in the decision-making process: 1) compliance with medications and 2) the use of drugs and alcohol. It also appeared that
there was a general divide between clinical and legal perspectives on the Board. One respondent stated that

we know that [he needs help] because he doesn’t know what his medications are, [and] we know that that if he goes out into the community, he’s going to use drugs. We don’t have anything to say that it’s going to happen, but what we’re saying is that in our clinical opinion, it’s probably what’s going to happen. That’s why it’s taking so long getting him into the community...we want to be better assured that all these things that he says he’s going to do, he’s actually going to do.

From a legal perspective, one counterargument was “why can’t you just let him go and see how he does”. In terms of medication compliance, it was stated that, “since the accused is passively compliant in the hospital, there’s a probability that he would be passively compliant too in the community”.

Approximately half of the respondents interviewed stated that split decisions were absolutely unpredictable and that there may simply be a disagreement about whether or not the accused poses a significant threat. The other half felt that factors, such as differences between legal and clinical perspectives, accounted for many of the splits. Further, it was stated by one respondent that in their opinion and based on their experience with the Board, it may depend on the issue of medication compliance, drugs and alcohol use, as well as differences in the way that the Board interprets and defines trivial harm. Additionally, it was stated by several respondents that split decisions were not always about deciding whether to grant someone an absolute discharge, but also whether the accused person ought to remain in custody or be granted a conditional discharge. Additionally, one participant asserted that the number of split decisions has decreased over the years - perhaps because the Board was receiving “better information during the hearing about risk and dangerousness”.

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From a legalistic perspective, it was stated by one respondent that the Board tended to “want evidence-based information to support what [they] think may be a significant threat to the public...and that’s where we clash a lot”. It was also stated that one of the things that needed to be considered was that, while in custody, the accused person is in a structured environment. (S)he is supervised 24 hours a day and have staff available to assist them with their medication. Although clinically, the accused is benefiting from the treatment team’s assistance, legally (s)he should be provided the opportunity to demonstrate some form of independence in the community. This held true especially if there was no legal evidence to suggest that (s)he posed a significant threat. This same dilemma was also shared from a clinical perspective. One participant stated that

for me, [an] interesting issue has always been, what exactly is my role?...When it comes to expressing an opinion, when it comes to voting time, I have to don my legal hat...what is the proper decision in law?...I may feel that there is a hopeless chance of this person adhering to medication and treatment in the community, and if given an absolute discharge, would simply fall off the edge, you know? So...I would feel [that] clearly the patient benefits from the care in the forensic system, and clearly such care would be guaranteed if the patient remained under the Review Board.

One participant stated that, based on their experience with split decisions within the Board, psychiatrists were most often the dissenting member. One respondent with a clinical background contended that, a few years ago, the decision-making from their end may have been more conservative but, perhaps as a result of Winko, that is no longer the case. It was stated that “conservatism comes with clinical experience in the past ... a simplistic legalistic approach where people with clinical backgrounds may be more hesitant”. It was further stated by another respondent, however, that regardless of who is dissenting,
a minority opinion is as important as the majority and must be communicated as clearly to the affected parties so people can assess whether or not [the] decision is one that should be appealed. Those are the rights that are given in the law. It’s called an expert tribunal that professionals like legal or helping professionals like doctors or psychiatrists automatically bring with them. You can’t leave it all at the door. To some extent, differing professional training or perspectives will have a bearing on decision-making, and I think that was intended…but I think that it can sometimes result in a division.

**Theme #7 – Important Factors to Consider**

Participants were given a series of factors and asked to comment on how much weight or importance was placed on them. Additionally, participants were invited to consider any other factors they felt were relevant. All respondents agreed that the factors offered were sufficient, and had no other significant ones to contribute. The specific factors asked were: a) the nature of the index offence; b) the severity of the mental illness; c) the length of time the accused has spent under the Board’s jurisdiction; d) how often the accused has appeared before the Board; e) the accused persons’ insight into his/her mental illness; f) the accused persons’ compliance with his/her medication(s); and g) community support for the accused. Throughout this portion of the interview, it was very common for respondents to reply with “it depends”. It became clear that, although each factor in itself may be relevant, each case was unique and, therefore, these specific factors could not be generalized to all accused persons.

**Nature of the Index Offence**

When asked about the importance of the nature of the index offence, respondents made comments, such as “the more serious the charge, the more difficult it is to get an absolute discharge” and “the more serious the index offence is, the more time the accused is given custody”. Several participants expressed a caution when there was a history of
dire criminal behaviour since it demonstrated the nature of the behaviour of which the accused person was capable. However, other respondents stated that, although the index offence was an important factor to consider, the physical outcome of the offence may have been a matter of chance. As such, the index offence could not always play such an important role in determining significant threat. It was also stated that, according to Winko, the index offence “is not to be considered unless it fits-in with other factors” but that it was pretty rare that other factors did not play a role.

Severity of the Mental Illness

The severity of the mental illness seemed to be of importance, but mostly in relation to the assessment of risk by the treatment team and, subsequently, to possible future behaviour. Comments made were “it’s more a question of how that illness affects them, and how well the accused was in control of it at the time of the hearing and into the future”, and “the real issue is how well the treatment team has been able to keep the individual’s behaviour under control and continue to do so”. Additionally, it was stated that “the severity of the illness may have little to do with the risk that they pose, but they are still caught by the definition of significant threat, so…it’s very fact-dependent”.

From a clinical perspective, statements were made such as “I will not recommend continued detention simply because the person is severely ill” and, “if the Board gave a conditional discharge against medical advice and I thought that the individual was certifiable, I might not let that person go”. One respondent stated

I think one has to be careful not to become overly protective. We have to understand that this is a forensic system...and it brings with it significant restrictions and liberties and interference in one’s life from outside agencies [especially if] the person poses a significant threat. Even if somebody is not certifiably mentally ill, but requires treatment, what I do is ensure a release plan with continuity of care and so on. The responsibility then folds on my colleagues.
in the civil psychiatric system because mental health issues should be taken care of in the civil system.

Length of Time under the Board’s Jurisdiction and Frequency of Appearance before the Board

The majority of respondents stated that the length of time an accused person spends under the jurisdiction of the Review Board does not affect their decision-making process as much as other factors. Respondents made statements, such as “I don’t think it plays a role, it’s not supposed to, but I guess the Board keeps that in mind”, and “not that fact alone, not in my opinion”. Others stated that the number of times an accused person appeared before the Board also did not play a significant role. Participants stated “I do my best not to be concerned unless something specific falls from the last order”, and “[it holds] little influence, very little...especially when the index offence is not so serious”. Other stated that an accused person is legally entitled to ask for frequent hearings therefore, it should not be an issue, particularly if there were significant changes to his/her situation.

Although many participants did not feel that the length of time spent under the Board’s jurisdiction or how often an accused appeared before the Board were not very important factors to consider, they did state a concern for accused persons who had been institutionalized for lengthy periods. One respondent stated

it’s interesting because for ones who have been before the Board for a long time, [the Board does] comment...I think that it’s misleading because what they say is that ‘it’s been too long and this person should be out’, and they may say...the illness is quite severe and the offence is quite serious...but if it was someone who was just here for a dine and dash, and they have been here for 20 years, then they tend to question the treatment team more as to ‘why can’t you find anything for him’? They’ve become more institutionalized, and they want to push the issue more in terms of placements for them in the community.
Another respondent stated:

we don’t have capping provisions, and NCRMD’s can spend around ten years if he or she is still considered a significant risk to the safety of the public...and the length of time that the accused has spent under the Board’s jurisdiction doesn’t play a role in the decision-making. But some Boards put it as a question to the treatment team [and ask] 'why is the accused still not moving on'? So, it’s always a question posed by the Review Board.

Generally, respondents agreed that the Board did not wish to see an accused person remain within the institution for longer than necessary, thereby reflecting an awareness of the criterion of “the least restrictive and least onerous disposition.”

However, if the treatment team does not recommend the discharge of an accused person, the Board ultimately has to decide whether to follow the clinical advice of the treatment team or to choose an alternative disposition. It was further asserted that, whichever disposition is chosen, the Board aimed for an eventual and supportive reintegration into the community.

When asked about whether the number of times of an accused appeared before the Board affected the Board’s decision-making, many participants commented on the length of dispositions - specifically with regard to short orders. From a clinical perspective, respondents raised concerns in relation to accused persons receiving several short orders in succession. One participant stated that

a succession of short orders may signal that there is disagreement between the Review Board and the hospital about the risk the patient poses or the level of supervision required. So sometimes we find that the Board gives short orders of four or six months and we have to prepare these reports at least a month before. So if you give a three or four month order, in my opinion, I don’t think that’s helpful. It raises expectations, sometimes unrealistically in the patient.

Another participant stated that, in their experience, Review Boards assume that giving a short order may “somehow prod [the treatment team] into action, [but] that’s a false perception on their part”. Although participants adopting a clinical perspective agreed
that the Board appeared to do their best to instil a sense of hope that the accused will eventually live independent from the system, the majority challenged the effectiveness of short orders.

Participants embracing a legal perspective commented differently on short orders. Participants stated that “the purpose of short orders is to see how the person is doing while encouraging them to get out of the system”, and “really what we are trying to do is divorce [ourselves] from the last order”. One participant stated

I think that short orders can have an impact for absolute discharges or conditional discharges. But, if the Board has tried on one or more occasions for the accused or the treatment team to do certain things to get [the accused] out into the community or to get an absolute discharge and all of these things have failed, than there is a likelihood that you’ll only be granting nothing less than a year. Then, it just ends up increasing the number of hearings each year.

**The Accused Persons’ Insight into his/her Mental Illness and Compliance with Medications**

Having insight into a mental illness and the need for ongoing treatment was found to be of great importance in the decision-making process. From both clinical and legal perspectives, participants stated that “if they don’t have insight, then their chances of taking medication are not good”, “this is one of the important dynamic risk factors...some people have no insight into their illness and yet they take their medications”, and “insight into mental illness, paves the way for taking responsibility for maintaining mental health and abating risk”. During this portion of the interview, several respondents asserted that insight and medication compliance also carried with it a future connotation. Statements made were that “the question there is to judge future compliance or likelihood of future compliance on an ongoing basis against their past experience” and “you have to connect it with the future connotation of significant threat”. Other
respondents discussed both static and dynamic factors involved in insight and medication compliance. One participant stated that

if you can manage the risk, even if the patient doesn’t agree… but they will take their medication and they show-up regularly for appointments, and they have no history of difficult aggressive behaviors in the hospital, and they have not been a management problem… then you can work with it, and continue to work on the issue of insight in the future.

Respondents asserted that, if insight and medication compliance could be maintained, it could greatly improve the likelihood of an accused person’s successful re-integration. However, it was contended that, even if the accused lacked insight, it was quite possible to maintain stability. It was stated that if possessing insight were a requirement of release, “then nobody would be getting out of the hospital”. Subsequently, there was also general agreement that, if an accused discontinued his/her medication without consulting the treatment team, the chances of decompensation increased much more rapidly. One participant stated that

there is a difference between passive compliance, a statement of future compliance, and if the individual will actually be compliant with their meds. It’s like saying ‘quitting smoking is easy, I quit ten times last year’.

Several respondents also commented on patient/doctor rapport. It was suggested that it was ‘key’ for patients to have a good rapport with their doctors. One participant stated that “sometimes the treatment team actually stops the meds just to see if there is in fact a difference”. It was further stressed that a strong rapport between the accused and the treatment team encouraged meaningful lines of communication and boded well with the Review Board.
Community/Social Support

When asked to comment on the importance of community support, respondents stated that support in the community was very significant as it creates a safety net or a safeguard for the accused. As a result, community support provides "a healthy social context to remain healthy" and "can [aid in recognizing] signs of decompensation". Several respondents stated that a support network could also reduce the risk posed in the community. With regard to an accused being a candidate for an absolute discharge, it was stated by one respondent that in terms of non-professional support, [the clinical team] can provide the accused with the kind of monitoring that can be drawn to the attention of the treatment team. Many people do not live near a forensic community clinic...even if they have no family or have lost contact with them, but they have an employer who is a friend, who keeps a close eye on them to ensure that they aren't doing drugs or drinking alcohol, and that they're compliant with their medication, then it's still possible to get an absolute discharge. They still have a good rapport. You basically want to see if they can function in the community if they get an absolute.

Several respondents also stated that the level of support required depended strongly on the needs of the accused. It was asserted that many forms of support depended on what was available in the community, and what was reasonable for the accused. For example, a respondent stated that an accused may not have any family but responds well to his/her treatment team. At some point, "it becomes unrealistic for [the Board] to depend entirely on the forensic psychiatric services to offer support...we must then be able to rely on other sources of community support, other systems, and other programs".

Chapter 5 provided the results for the quantitative content analysis portion of the thesis, as well as the seven themes which emerged from the qualitative interviews. The subsequent chapter will analyze and discuss the findings.
CHAPTER 6: ANALYSIS AND DISCUSSION

Introduction

This chapter provides a detailed examination and analysis of the quantitative and qualitative results of this study. It will include a discussion surrounding the findings of the quantitative and qualitative data, while highlighting the similarities and differences between them. First, there is an examination of the impact of the *Winko* decision on the decision-making process of the British Columbia Review Board. Additionally, the manner in which respondents interpreted 'significant threat to the safety of the public' is reviewed. Second, the conceptualization and assessment of risk is discussed, as well as the importance of whether to focus on the past, present, or future risk of an accused person. Third, factors that are deemed to be important during the decision-making process are also examined. Fourth, there is an examination of the clinical and legal divide that became evident throughout the interviews, as well as a discussion of the issues surrounding the process of split decision making on the Review Board. Last, there is an overall discussion regarding the impact of therapeutic decision-making on the Review Board.

Parallels and Disparities between the Quantitative and Qualitative Data

Impact of *Winko*

Based on the interviews conducted, many respondents stated that *Winko* only clarified to some extent what was already written in the *Criminal Code*. From a clinical
perspective, it appeared as though *Winko* had made a relatively minor impact. Many respondents stated that, although the Review Board often refers to *Winko* in its decision-making, there did not appear to be many pragmatic differences between pre- and post-*Winko* decisions. This makes sense since the legal implications of *Winko* have completely negated the decision made in *Orlowski*. Nevertheless, the legal respondents who were interviewed did not appear to view the implications of the *Winko* case as being ground-breaking in terms of the legal process for determining risk and whether an accused poses a significant threat to the safety of the public. From a clinical perspective, it makes sense that clinicians would still be reluctant to encourage the release of an accused person because, if that individual receives an absolute discharge, there is no guarantee that (s)he would access or receive the necessary services in the community. As a result, those board members who embrace a clinical perspective may tend to err on the side of caution and favour a continual sentence within the jurisdiction of the Review Board. In this sense, the legal implications of *Winko* would not have been perceived as being particularly significant.

As it was not possible for the researcher to sit in on the private deliberations of the Review Board, there was no way of knowing the true impact of *Winko*. Although the interviews and the written decisions provided some insight into the legal and clinical views of various members of the Board and other key players, being permitted to observe the deliberations would have allowed for a more comprehensive outlook on how members of the Review Board come to a determination of whether an accused person poses a significant threat to the safety of the public.
When examining the written decisions in relation to the impact of the *Winko* case, the frequency analysis demonstrated that the total percentage of references to *Winko* within all documents was 3.1%. Although the mention of *Winko* would not have occurred in pre-*Winko* documents, the average mention within documents during and post-*Winko* were 5.1% and 3.9% respectively. As such, there was a 1.2% decrease in the number of references to 'Winko' in post-*Winko* documents when compared to the year that the decision was handed down in the Supreme Court. This demonstrates that, although *Winko* is being mentioned in written decisions, the frequency of mention has slowly begun to decline.

A statistical report prepared by the British Columbia Review Board in 2004-2005, demonstrated that, although the number of cases removed from the forensic system from 1998-2000 was notably higher, the number of cases removed since then has gradually begun to decrease. This might suggest that the *Winko* case had an initial impact on the number of absolute discharge cases within the system but, over time, the numbers have slowly begun to return to 'normal'. The number of cases removed from the BC Review Board from 1997-2003 has been on average 91 per year. If the year during and after *Winko* is removed from the total (1999-2000), then the average number of cases removed was 87 per year. This demonstrates that in the year in which *Winko* was processed, there was an elevation in case removal. By the year 2004-2005, the number of cases removed dropped to 68 (British Columbia Review Board Statistical Report, 2005). *Winko* may have had an impact on case closures initially, but the numbers since then have slowly begun to decrease [see Table 6.1].
Interpretation of “Significant Threat to the Safety of the Public”

When respondents were asked how they interpreted ‘significant threat to the safety of the public,’ as stated in s. 672.54 of the Criminal Code, it was common for Winko to be quoted. It was clear that respondents were providing an explanation in light of the Winko decision, but they were not necessarily expressing their own personal interpretation. Additionally, several respondents made comments such as, “I’m trained by Winko”, alluding to the fact that their personal interpretation did not matter that much. One respondent even stated that he/she felt that it was “unwise and unprofessional to adopt an individual interpretation of the term”.

The mention of a future connotation was frequently made by respondents in their understanding of “significant threat.” This was reasonable because Winko includes a reference to “a foreseeable and substantial risk that the NCR accused would commit a...
serious criminal offence if discharged absolutely” *Winko v. British Columbia*, 1999: para. 69). Additionally, respondents pointed to the fact that “significant threat” included behaviours that were criminal in nature, and that these behaviours were not limited to only physical harm. *Winko* states that

the threat must also be "significant", both in the sense that there must be a real risk of physical or psychological harm occurring to individuals in the community and in the sense that this potential harm must be serious. A minuscule risk of a grave harm will not suffice. Similarly, a high risk of trivial harm will not meet the threshold. Finally, the conduct or activity creating the harm must be criminal in nature (*Winko v. British Columbia*, 1999: para. 57).

A legal - versus a clinical - divide was also apparent between the respondents interviewed. It became clear that the interpretation of “significant threat” differed slightly between those respondents coming from a legal perspective and those from a clinical background. From a legal perspective, statements regarding the interpretation of significant threat were based more on the legal analysis provided in *Winko*. For example, it was common for respondents to state that there was a need for evidence-based information in order to determine whether an accused posed a “significant threat.” In addition, respondents tended to quote sections of *Winko* to support their interpretation.

From a clinical viewpoint, the interpretation of “significant threat” was based more on a prediction of risk and being able to anticipate how an accused person would behave in the community if released. Although direct references to *Winko* were made infrequently during the interview, there were marked implications with respect to the ‘future’ element of *Winko*. For example, respondents often mentioned the need to predict to some degree the potential future threat of an accused.

Not surprisingly, within the written decisions, the mention of risk and threat was made more frequently than reference to any other factor or variable. Within the 36
documents, it represented 23.9% of the total references made. As the variable
‘risk/threat’ represented a variety of collapsed variables, it did not represent the true
number of how often the words ‘significant threat’ appeared within the documents. Of
the 580 references made to risk or threat within all of the documents, 230 were attributed
to the words ‘significant threat’ alone. This equates to 39.7%. It was also evident that in
post-*Winko* documents, significant threat was mentioned 1.6 times more often than in
pre-*Winko* documents. As the *Winko* case is focused on the issue of significant threat, it
seems only natural that the Review Board would mention it more frequently in their
decision-making.

**Predicting Risk**

The discussions in the interviews surrounding risk, the assessment of risk in the
forensic system, and the prediction of risk were very interesting. Using an excerpt from
one of the Review Board’s written decisions as an example, it was stated that

> We [the Review Board] are doing our utmost to responsibly predict the future,
and by definition, questions about future risk cannot be answered with certainty
or empirical precision. If they could, these inquiries would not be about “risk”.
Consequently, while doubt about the question of “significant threat” entitles a
person to an absolute discharge, doubt about the questions whether a criminal act
will certainly occur does not entitle a person to an absolute discharge. Even in
the face of a finding of significant threat, there is always doubt about whether
something will occur. A finding of significant threat does not demand
omniscience, psychic foresight and the absence of doubt. Such a requirement
would be entirely unrealistic and a serious misreading of the judgment (*R. v.
Hind, 1999*: 7).

It was made clear by respondents that it was of great importance to try to predict as best
as possible the level of risk that an accused person may pose if released into the
community. Several respondents commented on risk assessments such as the HCR-20.
Some used the HCR-20 as a guideline in determining risk, while others did not prefer to
rely on risk assessments at all. Overall, respondents tended to be of the opinion that focusing on past, present, and future risk were all of importance. The rationale was that past behaviour helped to establish a pattern, and present behaviour provided information regarding the current status of an accused person, thus permitting a prediction of future behaviour. As such, it was clear that both static and dynamic risk factors were being considered.

Interestingly, however, when examining the written decisions, the mention of formal risk assessments was infrequent. Within all written decisions, mentions of formal risk assessments only constituted 3.6% of all references and the frequency of mention was only 1.6 times more often in post-Winko documents. This indicates that, although risk assessments are being mentioned more often post-Winko, they are still not mentioned very often. The question then become, how is risk being assessed?

As aforementioned, some respondents stated that they use a risk-assessment tool similar to the HCR-20 as a clinical guide. Others stated that each case was unique and the method by which risk was determined varied accordingly. One respondent stated that “the clinical assessment of risk requires clinical expertise, requires forensic expertise, and requires a full awareness and familiarity with risk assessment instruments”. Although it was stressed that assessing risk was not an exact science, it was clear that formal risk assessments were being used to some extent - even if only as a guide - within the forensic psychiatric system. Given that nearly all risk assessments include historical variables that cannot change, and given that the majority of accused persons suffer from a co-morbid disorder that would affect his/her dynamic risk factors, it can only be expected that
everyone would pose some level of risk. As a result, the question then shifts to: what level of risk is sufficient to deny an absolute discharge?

*Winko* (1999) states that

the threat must also be "significant", both in the sense that there must be a real risk of physical or psychological harm occurring to individuals in the community and in the sense that this potential harm must be serious. A minuscule risk of a grave harm will not suffice. Similarly, a high risk of trivial harm will not meet the threshold (para. 57).

When asked about the difference between minuscule risk, grave harm, and trivial harm, respondents from a clinical background were not familiar with the terms. This did not come as a surprise as these terms stemmed from the legal decision in *Winko v. British Columbia* (1999) and were mainly limited to the respondents on the Review Board and legal counsel interviewed. What this does demonstrate, however, is that the treatment team submits to the Review Board an opinion regarding the level of risk posed regardless of what is stated in *Winko*, and then it is left to the Review Board to determine whether that 'risk' falls into one of the three categories.

What is interesting is that there is no official legal definition for any of the three terms provided in the Criminal Code. Although respondents interviewed were able to provide clear examples of what they thought to be minuscule risk and grave harm, there was no consensus as to what constituted a trivial harm. As one respondent stated, "exactly what counts as a trivial harm? ...That is the area were disagreement will most likely occur". Although it was clear that respondents were able to provide examples of what they deemed to be a trivial harm, there were still slight differences in the manner in which it was interpreted. For example, some respondents contended that there was a clear distinction between minuscule risk and trivial harm, while others stated that there might be a bit of overlap between the two terms.
Interestingly, many terms found within the Criminal Code are subject to some form of interpretation as they are not necessarily defined. For example, how does one define and interpret the term ‘reasonable’? At some point the definition has to be subjective.

**Risk Factors to Consider**

It was evident through the results of the frequency analysis that the most commonly made reference within all of the documents was that of ‘threat’ (23.9%), more specifically ‘significant threat’ (39.7% of 23.9%). This did not come as a surprise, since one of the main goals of the Review Board is “to improve protection for society against those few mentally disordered accused who are dangerous” (British Columbia Review Board, 2003a). As such, it seems only natural for the Review Board to make several references within their written decisions as to whether the accused poses a significant threat to the safety of the public.

When examining the breakdown of the variable ‘risk’, it was mentioned that ‘previous violence’ represented a large number of the references (17.8%), followed by ‘criminal history’ (11.2%). However, post-*Winko*, the mention of ‘previous violence’ increased slightly while references made to ‘criminal history’ decreased. Although there was an overall increase in the mention of ‘risk/threat’ in post-*Winko* documents, it was only 1.2 times more often, which is a smaller increase than was anticipated. This might suggest that *Winko* has not necessarily altered the way that the Review Board examines the concept of ‘risk’ or ‘threat’.

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67 Since the coding in the content analysis was objective, references made to ‘threat’ did not always attach a negative connotation. Even if the word was simply used in passing, it was recorded. As the entire Review Board decision-making process revolves around the concept of ‘significant threat’, it was expected that the frequency of references would far exceed that of any other reference within the documents.
Initially, it was no surprise that the frequency of references made to ‘substance use’ was elevated within all of the documents (10.1%). What was surprising was that the majority of the references were made during pre-Winko documents. This may have been a result, however, of the documents chosen for the study. In other words, there may have been more decisions pre-Winko where drugs were a major issue for the accused person, thus increasing the reference count within that period. Research does suggest that a large proportion of mentally disordered accused persons suffer from a co-morbid disorder, meaning that in addition to their diagnosed mental illness, they suffer from a drug or alcohol addiction (Monson et al., 2001). This finding was also supported by respondents in the interviews, who stated that it is often a concern that an accused person will discontinue his/her medication, recommence non-prescription drug use, and relapse. An excerpt from one of the written decisions stated that “continued marijuana usage must be seen as adding to the risk of violence” (R. v. Dixon, 1998: 4). As such, although ‘substance use’ may not have been used often within written documents, it certainly ties in with the issue of medication compliance and the associated risk of relapsing. As a high number of crimes committed by accused persons are substance-induced (Livingston et al., 2003), it seems reasonable that a Review Board would be concerned about substance abuse and non-compliance with treatment. Further, this concern could seemingly provide enough substantiation to support the conclusion that an accused person would in fact pose a threat to the safety of the public.

Within the written decisions, 'medication compliance' constituted 7.3% of all of the references made. Post-Winko, however, this factor was mentioned more than four times more frequently. Tying in heavily with medication compliance was 'insight into
illness'. Although 'insight' only constituted 4% of the total references within all of the documents, post-Winko, the factor was mentioned more than twice as often.

Additionally, respondents in the interviews asserted that insight into a patient's illness was a very essential aspect of determining his or her potential risk.

Many respondents stated that medication compliance was not a particularly pressing issue, as long as the accused was passively compliant with his/her treatment orders. That is to say that, even if an accused person possesses little insight into his/her illness or refuses to believe (s)he is ill, as long as (s)he passively complies with taking his/her medication regularly, then risk is abated. In relation to medication compliance, it was stated in one of the written decisions that "anything can happen in a year" (R. v. Owens, 1999: 6). This demonstrates that the Review Board members are cognizant that nothing is absolute. On the other hand, in another written decision, it was stated that "a plea for an absolute discharge was rejected on the basis that even with medication compliance, [the] family dynamics were such that the stress they created could themselves give rise to decompensation" (R. v. Rashead, 1999: para. 17).

As Winko includes a future connotation, it provides a considerable leeway for decision makers to keep someone in the forensic system based on an assessment of risk factors, such as the possibility of returning to substance use, or the possibility of non-compliance with medications. Winko also states that the Supreme Court is not going to overturn a decision by second-guessing the expertise of the tribunal members, as Parliament ensured that its members have special expertise in evaluating fully the relevant medical, legal and social factors which may be present in a case: [as per] s. 672.39 [of the Criminal Code]. If the court or Review Board, after reviewing all the relevant material, cannot or does not conclude that the NCR accused poses a significant threat to public safety, it must order an absolute discharge (Winko v. British Columbia, 1999: para. 55).
As such, so long as the members of the Board do not exceed their jurisdiction, they have the authority to order that an accused person remain either in detention or on conditional discharge, provided the accused is found to be a significant threat\textsuperscript{68}.

References made to ‘illness and history’ represented 8.9% of all references within the written documents. This variable included static factors such as the diagnosis of the accused, in addition to his/her previous mental health history. This finding implies that the Review Board deems this static factor to be of importance when determining the level of risk posed by the accused person. Previous research on determining levels of risk has shown that many clinicians still use static factors to help gauge some level of future risk (Glancy & Chaimowitz, 2005; Moran et al.; 2001; Ward & Eccleston, 2000). During the interviews, it was stated that the more severe the illness, the more vigilant the Review Board members were in requiring updated information concerning the accused person from the treatment team.

Interestingly, there was not a large increase in the frequency of the mention of ‘illness and history’ in post-\textit{Winko} documents. Within post-\textit{Winko} decisions, references to ‘illness and history’ increased in by only 1.4 times. Since \textit{Winko} attaches with it a future connotation, static or unchangeable factors may not be as pivotal in the determination of potential risk as say, dynamic or changeable factors. It must be noted, however, that although ‘personality’ is a fixed factor, the subsequent behaviours are not. For example, the Review Board may not be as concerned with the actual diagnosis as they are with the possibility of aggressive outbursts or psychotic episodes that occur as a

\textsuperscript{68} \textit{Winko} states that the Review Board must chose a disposition which is the least onerous and least restrictive for an accused person. In addition, as determined in \textit{Penetanguishene Mental Health Centre v. Ontario} (Attorney General) (2004) and \textit{Pinet v. St. Thomas} (2004), which ever disposition is chosen, the conditions within that disposition must also be the least onerous and restrictive.
result of the disorder. As a result, the diagnosed illness, in combination with other relevant risk factors, then becomes very significant in determining the potential threat exhibited.

In one of the written documents, it was clear that a variety of risk factors were all considered to be of importance in the Board's decision-making process. It was stated that a plan should be undertaken slowly, with careful monitoring, over an extended period of time. The greatest risk will be in the year following discontinuation of all medication, but given the seriousness of the index offence, plus other risk factors, including a history of substance abuse, lack of employment stability, presence of personality disorder, and ready access to a potential victim, it is my opinion he will need close follow-up and supervision, assuming he remains stable, for a minimum of two years (R. v. Harvey, 1999: 8).

Lastly, community/social support was of great importance to respondents in the study. Within the written decisions, 'social support' represented 5.5% of the total references. Post-Winko, references made to social support did not increase markedly, but increased nonetheless (1.6 times more often). During the interviews, respondents stressed the importance of the accused person's having support in the community upon his or her release. For example, respondents stated that familial support, support by an employer, or even support by a treating psychiatrist could prove to be crucial in ensuring stability in an accused person's life. Several respondents pointed to the fact that, if an accused does not have any support in the community, there may not be anyone present to detect signs of mental decompensation. One respondent interviewed stated that at some point it becomes unrealistic for [the Review Board] to depend entirely on...forensic psychiatric services, and [the Review Board] must...be able to rely on other sources of community support, other systems, and other programs that other have access to.

Studying the written decisions and analysing their content may be misleading, because it may actually not truly reflect the risk factors that the Review Board deems to be of utmost importance to consider. As such, it is important to compare results with
other studies that have been conducted on mental health tribunals. Although research in
that field is scarce, Peay (1989) studied the decision-making processes of mental health
tribunals in England Wales and was able to sit-in on their private deliberations. Her
research indicated that tribunals tended to focus primarily on therapeutically-based
outcomes, and often followed the recommendations of the psychiatrist sitting on the
tribunal. Specifically, Peay found that, in many of the tribunal decisions where the
outcome was a discharge, there was support by the patient’s RMO (Responsible Medical
Officer) or social worker.

Peay (1989) also found that insight into illness, medication compliance, remorse
from the accused, and an absence of the disorder or cessation of delusions were all major
factors in the decision-making process of the tribunal. Interestingly, all but one of these
factors in Peay’s study was of great importance within this study. Feeling a sense of
remorse is not really a concern with mentally disordered accused persons in Canada, as
they would have lacked the mens rea at the time of their offence anyway. Although
many accused persons feel a sense of remorse for the crime(s) they have committed, it is
certainly not a requirement or a condition for an absolute discharge, as they are not held
criminally responsible.

Clinical versus Legal Opinions

It was evident throughout the study that a divide existed between the treatment
team and Review Board members with a background in psychology versus the legal
members of the Review Board and counsel. These differing viewpoints resonated
throughout the interviews, as well as in the written decisions.
When comparing the average number of references to legal versus clinical risk factors within written decisions, it was found that there was an increase in both legal and clinical factors in post *Winko* documents; however, there was a larger increase in clinical references (See Appendix D for a list of clinical and legal factors). On average, clinical factors were mentioned approximately 36 times in each decision pre-*Winko*. However, Post-*Winko*, the average jumped to approximately 50 references per document. On the other hand, legal factors were mentioned around 22 times in each decision pre-*Winko*, and only 28 times post-*Winko*. This would indicate that *Winko* may have increased the attention paid to clinical risk factors when determining whether an accused person poses a significant threat.

Perhaps the reason why clinical risk factors are being mentioned more often post-*Winko* is a result of the adoption of a more therapeutic approach to the reintegration of an accused person. *Winko* states that “any restrictions on the liberty of NCR accused are imposed for essentially rehabilitative and not penal purposes” (*Winko v. British Columbia*, 1999: para. 94). If that is the case, although the liberties of an accused person cannot be infringed upon, it is clear that the therapeutic value of rehabilitative treatment is of great importance.

**Split Decisions on the Board**

Split decisions among Board members was an interesting topic, as there appeared to be two major reasons for a split on the Board: 1) compliance with medications and 2) the use of drugs and alcohol. Although it was stated that the frequency of split decisions was quite low, it was evident that in many cases, splits existed where there was a disagreement between those who focussed on the legal and constitutional rights of an
accused person and those who embraced a more clinical and therapeutically-based approach. For example, with respect to medication compliance, it was stated that - from a clinical point of view - there lies a fear that, if an accused person receives an absolute discharge, (s)he will no longer be legally required to continue with his/her medical treatment. Consequently, if (s)he discontinues his/her medications and relapses, there are no mandated services in place to ensure his/her personal safety or the safety of others. Given that over 20% of crimes committed by mentally disordered offenders occur while they are under the influence of drugs or alcohol (Livingston et al., 2004), the possibility of additional drug or alcohol abuse taking place in the future is also of great concern to those who adopt a clinical perspective.

From a legal perspective, however, Winko states that if the Review Board cannot come to definitive conclusion that the accused may pose a significant threat to the safety of the public, (s)he must be discharged absolutely. Therein lies the conundrum that Winko poses. How does one balance the legal rights of the accused with the therapeutic value of ongoing treatment?

**Therapeutic Decision-Making**

It was evident throughout the interviews that members of the Review Board and others involved in the decision-making process very much valued the need for therapeutic outcomes. Winko (1999) states that

Part XX.1 [of the Criminal Code] protects society. If society is to be protected on a long-term basis, it must address the cause of the offending behaviour -- the mental illness. It cannot content itself with locking the ill offender up for a term of imprisonment and then releasing him or her into society, without having provided any opportunities for psychiatric or other treatment. Public safety will only be ensured by stabilizing the mental condition of dangerous NCR accused (para. 40).
It is made clear that treatment initiatives are crucial; however, *Winko* also stresses that, if the accused no longer poses a significant threat to the safety of the public, then (s)he must be discharged absolutely. As such, therein lies a conundrum. If treatment is such an integral part of the process, then what happens to an accused once they no longer pose a threat as per s. 672.54 of the *Criminal Code*? Is it left to the civil system? Within the province of British Columbia, individuals can be forcibly treated. From a therapeutic viewpoint, is it more valuable to forcibly treat someone who is mentally ill? At what point does the therapeutic intent of treatment become legally and morally intrusive?

Winick (2004) states that coercion may sometimes be necessary for those who are severely mentally ill; however, he gives warning of the potential anti-therapeutic consequences of forcible treatment. Instead he states that alternative methods, such as persuasion, education, negotiation, and inducement are more successful means to achieving compliance. Specifically, Winick asserts that clinicians should act toward their patients in ways that minimize the perception of coercion and maximize the patient’s sense of voice and inclusion and the patient’s appreciation that the treatment imposed is benevolently motivated and administered in good faith (1994: 344-345).

Arguably, although Winick’s contentions are valid in theory, if an accused person is discharged absolutely, (s)he may not actually receive the mental health services and support in the community that are necessary for him or her to remain mentally stable. As such, it poses a dilemma. What carries more weight in the decision-making balance - the civil rights of an accused person, or the therapeutic value of treatment?

This chapter provided an analysis of the findings obtained during the course of this study. Last final chapter will discuss the implications of the findings, in addition to recommendations for future research.
CHAPTER 7: IMPLICATIONS AND RECOMMENDATIONS

Introduction

The aim of this study was to examine the effects of the Supreme Court of Canada's ruling in Winko (1999) on the decision-making process of the British Columbia Review Board when it is charged with deciding whether or not to grant an absolute discharge to an accused person. It was of interest to examine how the Board interpreted and applied the concept of 'significant threat to the public safety,' as required by s. 672.54 (a) of the Canadian Criminal Code. Additionally, the frequencies of references to specific factors within written British Columbia Review Board decisions were examined and evaluated as to their potential importance in the determination of risk.

Summary of Findings

The results of this exploratory study indicated that the effects of the Supreme Court decision in Winko v. British Columbia (1999) were varied. Based on the content analysis of 36 written B.C. Review Board decisions, many risk-related factors were mentioned more frequently within decisions post-Winko. There appears to be a heavier reliance on -or greater frequency of mention of - information regarding medication compliance, insight into illness, and community support. Specifically, insight into illness and medication compliance seemed to be major factors when determining whether to grant an absolute discharge to an accused person. Substance use as a risk factor was not formally raised in the interview, but was mentioned several times by respondents as a
concern. It would be interesting to conduct a follow-up study to determine if this increased frequency of mention to factors such as medication compliance, insight, and community support would continue at the same level, would become even more marked, or would or return to the same frequency pre-Winko.

During the interviews, when asked about the interpretation of ‘significant threat to the safety of the public’, as specified in s. 672.54 of the Criminal Code, the majority of respondents quoted Winko, and provided examples of forms of harm that an accused person may inflict. It was clear that individuals who adopted a legal perspective provided different interpretations than individuals who came from a psychological or social-work background. In the future, it would be of interest to develop a study, which compares decision-making from both legal and clinical points of view.

It appears as though standardized risk assessments, such as the HCR-20, are still being used; however, they are only being used as guidelines and not in their original purpose. There appears to be some encouragement for members of the treatment team to start using the Short-Term Assessment of Risk and Treatability (START). That being said, Review Board members seem to be reluctant to rely too heavily on these types of risk assessments. This is possibly because they are best used as a guideline while focusing on risk management factors, as was recommended by many of the respondents interviewed.

Since this study only examined written Review Board decisions within the province of British Columbia, it is not possible to generalize the findings to all Canadian provinces. Additionally, only 12 interviews were conducted and it may have been advantageous to obtain more. Future studies may wish to conduct a national survey of
the effects of *Winko* which would include interviews with various members of the Review Board and other stakeholders from across the country. Secondly, as it was difficult to acquire written decisions in *Quicklaw* prior to 1998, many of the decisions were chosen on the basis of convenience of access and were provided to the researcher from an archived collection at the B.C. Review Board's head office. As such, some of the cases may not have truly reflected the "average" decision-making process of review boards across Canada. The possibility remains that the cases in this study may have been sensationalized or high-profile, thus focusing heavily on specific risk-related factors. As a result, there may have been an unusual elevation in the frequency count of certain risk factors. Additionally, given that the study was not random in its selection process, only a simple frequency analysis was possible, thus limiting the statistical strength of the findings.

Even though the coding of the data in the content analysis aimed to be as objective as possible, it would have been beneficial to have a second coder so that a form of inter-rater reliability could have been established. As this study was only exploratory, and had no *a priori* expectations, it was still possible to provide some solid insight into the impact of *Winko* on the decision-making processes of the British Columbia Review Board.

One of the major advantages to this study was that no substantial research had yet been performed on the effects of the *Winko* case in relation to the decision-making process of Review Boards, specifically within the province of British Columbia. The advantage to utilizing written decisions in this study was that it permitted the researcher to identify key factors that appeared to be of importance to the Review Board.
Additionally, the interviews provided the necessary depth required in order to demonstrate the views of the *Winko* case and how it has affected the Board's decision-making process.

**Where to Go from Here**

A study of this nature begs a number of questions. The Supreme Court of Canada stated that, as a result of the decision made in *Winko*, if a Review Board cannot come to a definitive conclusion that an accused person poses a significant threat to the safety of the public, then the accused must be discharged absolutely. If this is the case, then what happens to accused persons once they are discharged? Where do they go? What if they have no family or friends to support them and monitor signs of decompensation? Do they 'fall in between the cracks' and wind-up in a revolving-door situation? Do they actually access the necessary services in the community? What happens if medication compliance is no longer a requirement?

It makes sense that the impact of *Winko* would not have been particularly marked if there had been a heavier focus by the Review Board and treatment teams on therapeutic outcomes. Although the legal implications of *Winko* are clear, the clinical implications resonate as well. *Winko* acknowledges that "providing opportunities to receive treatment, not imposing punishment, is the just and appropriate response" (*Winko* v. *British Columbia*, 1999: para. 41). Nevertheless, *Winko* states that the Review Board must impose the least restrictive and least onerous disposition on an accused person. Additionally, as a result of the 2004 twin cases *Penetanguishene Mental Health Centre* v. *Ontario* (Attorney General) & *Pinet* v. *St. Thomas*, the Supreme Court of Canada ruled that, within any given disposition, the conditions themselves must be the least onerous
and restrictive. Within the province of British Columbia, the effects of these cases may not be as significant as they are in Ontario because British Columbia only has one forensic hospital. Within the province of Ontario, there are several forensic institutions that range in levels of security. As such, it would be interesting to study whether the Ontario Review Board has made any changes in the way they assess risk, and impose conditions within their dispositions. That aside, if the Review Board must impose the least restrictive alternative, then how can they ensure that the accused person is still receiving the necessary treatment required in order to maintain ongoing mental health and stability? Interestingly, in the 2006 in the Supreme Court ruling of R. v. Mazzei, it was decided that a Review Board has the power to make conditions regarding the provision and supervision of medical treatment, and to make such conditions binding on other parties such as hospital authorities. This power is justified by the statutory role and mandate of Review Boards; yet it is a limited mandate, since Review Boards cannot go so far as to actually prescribe or impose medical treatment, or require hospital authorities to deliver that treatment.” (Mazzei, 2006: para. 67).

As such, from a therapeutic standpoint, the Review Board may now exercise a supervisory role over treatment. It would be valuable to examine the effects of this ruling and if it has changed the dynamic between Review Boards and Treatment Teams.

Winko states that the Review Board has to give-up jurisdiction if an accused person no longer poses a significant threat to the safety of the public. As such, an inherent tension exists. Although the Review Board’s intent is to balance the needs of the accused person with public safety requirements, the therapeutic needs may not be met if the accused person is no longer receiving treatment under the jurisdiction of the Review Board. Winko also states that, if the accused person is longer a significant threat to commit a crime but still requires mental health treatment, the Review Board can only
recommend that (s)he be accepted into the civil system for ongoing treatment. However, if an accused person is then civilly committed in the community and refuses to take his/her medication, there are consequences. For example, if a person is released on conditions - now referred to as outpatient commitment - the patient may be recalled to the psychiatric facility from which (s)he has been released.

If one is therapeutically inclined, it makes sense to seek to do everything to ensure that an accused does not relapse. However, Winko states that the Review Board cannot permit that unless the accused poses a significant threat. How is this tension resolved? There appears to be a constant battle between the constitutional rights of an accused person for autonomy and the therapeutic value of ongoing supervision. Interestingly, based on the results of the content analysis and based on the professional opinions of those interviewed in the study, the risk factors deemed to be of utmost importance will ensure, to some extent that an accused will remain under the jurisdictions of the forensic mental health system for a long period. For example, there is now an increased mention of factors such as illness history, insight, medication compliance and community support. Since illness and mental history cannot be changed, insight is usually limited, medication compliance may lapse if the accused is discharged absolutely, and community support may be dismal, it may be the case that an accused be held under the Board’s jurisdiction longer than expected, provided that all of these risk factors point to the potential risk of committing another crime.

The therapeutic approach may be more dominant within the forensic psychiatric system even though the law is anti-therapeutic in releasing accused persons. These accused persons still require important mental health services, ongoing
support, and supervision in the community. It then becomes a social problem because the service is cut-off unless the accused commits another offence and is found to be NCRMD. On the other hand, an accused may end-up with a guilty conviction and go to a correctional facility. This would be even worse because (s)he may not receive any adequate or helpful treatment services while in that correctional facility. Even though specialized courts, such as mental-health courts, have been designed to resolve that issue, they too pose a problem, as they may simply encourage a guilty plea and increase the conviction rate. Ultimately, is it even fair to be using the system in order to access mental health services? These courts may simply be a net-widening 'black hole' which exhaust the resources available for mental health services in general. While this may provide an advantage for forensic clients, it may come at the expense of non-forensic mental health consumers.

To conclude, perhaps it would be more useful to focus on risk management factors while in the forensic system. From a policy perspective, this is a very interesting issue as it calls into question whether the appropriate legislation is in place to handle these risk management factors and whether the appropriate services are in place to support accused persons living in the community.

Since these individuals are not criminally responsible on account of a mental disorder, dispositions are not about punishment. This has been made especially clear in Winko. As such, the dignity of mentally disordered offenders must be preserved at all times. From a therapeutic standpoint, one can only assume that regardless of what risk factors are being examined and regardless of what the impact of Winko has actually been on the Review Board, if the effect of the law has been to inherently produce anti-
therapeutic consequences, then no matter how therapeutic the decisions are intended to be the end result is irreconcilable.

There appears to be some utility in embracing Therapeutic Jurisprudence as a means of enhancing the mental health outcomes for patients who fall under the jurisdiction of the Review Board. Thus, one can only hope that future therapeutic decision-making will permit a greater success for accused persons reintegrating into the community. The underlying paradox is that this is body that expects to follow these therapeutic ideals is tainted by legal doctrine. Essentially, if an accused person is no longer a significant threat to the safety of the public and receives an absolute discharge, then the Review Board no longer has permission to exert ongoing supervision. As such, an accused person may ‘fall through the cracks’ and no longer receive the necessary medical treatment within the provincial civil mental health system. Therefore, as it stands, the current legal doctrine and Charter rights make it difficult to act with a therapeutic motivation. In the future, it would be interesting to conduct a longitudinal study and follow accused persons in the community to determine what actually becomes of them once discharged absolutely, and examine what can be realistically put into place to ensure that an accused person accesses these essential services in the mental health system.
APPENDICES
Appendix “A”

Informed Consent by Participants in a Research Study

The University and those conducting this research study subscribe to the ethical conduct of research and to the protection at all times of the interests, comfort, and safety of participants. This research is being conducted under permission of the Simon Fraser Research Ethics Board. The chief concern of the Board is for the health, safety and psychological well-being of research participants.

Should you wish to obtain information about your rights as a participant in research, or about the responsibilities of researchers, or if you have any questions, concerns or complaints about the manner in which you were treated in this study, please contact the Director, Office of Research Ethics by email at hweinber@sfu.ca or phone at 604-268-6593.

Your signature on this form will signify that you have received a document which describes the procedures, possible risks, and benefits of this research study, that you have received an adequate opportunity to consider the information in the documents describing the study, and that you voluntarily agree to participate in the study.

Any information that is obtained during this study will be kept confidential to the full extent permitted by the law. Knowledge of your identity is not required. You will not be required to write your name or any other identifying information on research materials. Materials will be maintained in a secure location.

Title: The Disposition of Not Criminally Responsible Accused Persons in British Columbia: The Impact of the Winko Case on the Decision-Making Process of the British Columbia Review Board
Investigator Name: Lindsay Broderick
Investigator Department: School of Criminology

Having been asked to participate in the research study named above, I certify that I have read the procedures specified in the Study Information Document describing the study. I understand the procedures to be used in this study and the personal risks to me in taking part in the study as described below:

Risks to the participant, third parties or society:

None
Personal Risks:

None

Personal Benefits:

One of the major advantages of this low-risk exploratory study is that no real research has been performed on the effects of the Winko case (1999) with respect to the element of risk, the interpretation of section 672.54 (a) in the Criminal Code, and the decision-making for the Review Board. A second major advantage to this study is that there has been an interest on behalf of the Forensic Psychiatric Hospital to examine the effects of the Winko decision (1999).

With regard to the qualitative component, the advantages of being a complete observer in the field are that informed consent is generated from the beginning; however, in this case consent is not required because review hearings are open to the public. When performing the open-ended interviews, the advantage is that the researcher is able to listen to the professional opinions of the Board members and other relevant participants. This is an advantage because it allows for an opportunity to hear their voices and opinions regarding the impacts of the Winko case (1999) and its relation to the interpretation of significant risk during the decision-making process.

Benefits of study to the development of new knowledge:

One of the major advantages of this low-risk exploratory study is that no real research has been performed on the effects of the Winko case (1999) with respect to the element of risk, the interpretation of section 672.54 (a) in the Criminal Code, and the decision-making for the Review Board. A second major advantage to this study is that there has been an interest on behalf of the Forensic Psychiatric Hospital to examine the effects of the Winko decision (1999).

With regard to the qualitative component, the advantages of being a complete observer in the field are that informed consent is generated from the beginning; however, in this case consent is not required because review hearings are open to the public. When performing the open-ended interviews, the advantage is that the researcher is able to listen to the professional opinions of the Board members and other relevant participants. This is an advantage because it allows for an opportunity to hear their voices and opinions regarding the impacts of the Winko case (1999) and its relation to the interpretation of significant risk during the decision-making process.

The advantage of the quantitative portion of this study is that the data will be relatively simple to collect. In addition, when using archival data, such as the decisions on the web, it is possible to perform longitudinal studies in the future. This will be valuable if the researcher wishes to perform a larger, more comprehensive study at a later time. In addition, the cost in using archival measures is also much cheaper, and the reactivity is generally reduced.
Procedures:

The qualitative component of the study is considered to be exploratory. This will involve interviewing the three Review Board members, who sit as a panel in any given case, as well as the defence counsel (e.g. members of CLAS-Community Legal Assistance Society), the Crown, the hospital-appointed psychiatrist and the treatment team. In order to interview these individuals, the experimenter will attend public review hearings. One-hour interview sessions with the respondents will be held following the public review hearings or at a convenient time. It is important to sit-in on a number of public hearings in order to appreciate some of the various characteristics of the setting in question. Due to the fact that various participants in the review hearings rotate, it will be imperative to sit-in on a number of hearings and receive interviews from various members.

Members of CLAS and of the Crown will be interviewed first, followed by the treatment team and the Board members. The interviews will be semi-structured and the particular questions will be prepared by the researcher. The specific questions will allow the respondent to provide their view of the impact of the 1999 Winko decision, specifically with regards to determining significant risk. The interviewer will ask the respondent a series of questions that pertains to the criteria that was laid out in Winko (1999). It will also be asked whether the Winko case has affected the way that they review each case. Based on the response given, the interviewer will ask how the Winko decision has or has not impacted them.

The questions asked will be directly related to the research question and hypotheses, and will aim to be as straightforward as possible. The research objectives will be made clear to the respondents, and the open-ended questions will provide them the opportunity to discuss how they feel the Winko case has affected them professionally or affected the Board's decision-making process as a whole. There will be an approximate maximum of seven questions that will be asked to limit inconveniencing the respondent. The researcher will also try to obtain consent to use a recording device in the event that the respondent is unable to accurately write down the answer in its entirety. The researcher will also be careful to word the interview questions in such a way that they do not cause any ambiguities or lead the respondent in a certain direction. All responses will be kept strictly confidential and anonymous, and any identifying information will be destroyed after the thesis defence. Additionally, during the collection of data, all identifying documents will be kept in a separate location from the responses given.

I understand that I may withdraw my participation at any time. I also understand that I may register any complaint with the Director of the Office of Research Ethics or the researcher named above or with the Chair, Director or Dean of the Department, School or Faculty as shown below.

Department, School or Faculty: Chair, Director or Dean:
School of Criminology Dr. Simon Verdun-Jones

8888 University Drive
Simon Fraser University
I may obtain copies of the results of this study, upon its completion by contacting:

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I have been informed that the research will be confidential.

I understand that my supervisor or employer may require me to obtain his or her permission prior to my participation in a study of this kind.

I understand the risks and contributions of my participation in this study and agree to participate:

Participant Last Name:  Participant First Name:

Participant Contact Information:

Participant Signature:  Witness (if required):

Date:
Appendix “B”

Interview Questions

1) What do you think is most important when assessing ‘significant risk’?

2) How do you interpret ‘significant threat to the safety of the public’?

3) What do you think the impact of Winko has been on determining individual risk? (as opposed to Orlowski)

4) Do you focus on present risk or future risk?

5) How is risk being assessed (e.g. risk assessments)?
   a- How do you measure miniscule risk, grave harm and trivial harm (as stated in Winko)?

6) What is the process in a split decision? Are there certain factors usually related to split decisions?

7) How do these factors play a role in the decision-making process:
   a- the nature of the offence
   b- the severity of the mental illness
   c- the length of time the accused has spent under the Board’s jurisdiction
   d- how many times the accused has appeared before the Board (e.g. short orders)
   e- insight into their mental illness
   f- compliance with medication(s)
   g- community support
### Appendix “C”

#### Original List of Variables for the Content Analysis

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Appendix “D”

Clinical Variables
- Mental State
- Social Skills/Attitudes
- Behaviour in Community
- Substance Use
- Insight into Illness
- Medication Compliance
- Self-Harming Behaviours
- Mental Illness and History
- Risk Assessments
- Behaviour in Hospital
- Social Support
- Community Involvement

Legal Variables
- Winko
- Other Law Cases
- Length in Forensic System
- Index Offence
- Risk/Threat
- Victim Impact Statement
Appendix “E”

Section 672.54 of the *Canadian Criminal Code (post-Winko)* states:

Where a court or review Board makes a disposition...it shall, taking into consideration the need to protect the public from dangerous persons, the mental condition of the accused, the reintegration of the accused into society and the other needs of the accused, make one of the following dispositions that is the least onerous and least restrictive to the accused:

a) where a verdict of not criminally responsible on account of mental disorder has been rendered in respect of the accused and, in the opinion of the court or Review Board, the accused is not a significant threat to the safety of the public, by order, direct that the accused be discharged absolutely;

b) by order, direct that the accused be discharged subject to such conditions as the court or Review Board considers appropriate; or

c) by order, direct that the accused be detained in custody in a hospital, subject to such conditions as the court or Review Board considers appropriate.
REFERENCES

Works Cited


Department of Justice Canada (2002). Review of the mental health provisions of the Criminal Code. Accessed on the 16th of September, 2005, @


http://www.forensic.bc.ca/fpsh/fpsh.html.


Index of Cases


