

**GEOGRAPHICAL RELEASE PATTERNS AND
CHARACTERISTICS OF NOT CRIMINALLY
RESPONSIBLE ACCUSED PERSONS DISCHARGED INTO
THE COMMUNITY:
AN ENVIRONMENTAL PERSPECTIVE**

by

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ABSTRACT

This thesis examines crime and mental disorder as it relates to Not Criminally Responsible accused persons who are released from hospital custody. Forensic research has traditionally neglected the potential contextual and environmental influences affecting patients who are placed in the community. Therefore, the following issues arise: where do forensic patients reside after conditional release from hospital and how do the environmental characteristics of a community affect successful reintegration? These questions are addressed through an examination of hospital records relating to those patients released on conditional discharge in the Lower Mainland area of British Columbia from 1998-2003. Results indicate that released accused persons predominantly migrate towards communities in Vancouver and Surrey that exhibit features of social disorganization—the same neighbourhoods that surround forensic out-patient clinics. Implications for research and release planning are discussed. It appears there exists great potential for including geographic perspectives in the study of mental disorder and crime.

Keywords:

Mental Disorder, Environment, Forensic, Community, Discharge

To Andrew Melnychuk, for believing in me unconditionally
and often beyond my abilities.

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TABLE OF CONTENTS

Approval	ii
Abstract	iii
Dedication	iv
Acknowledgements	v
Table of Contents	vi
List of Figures	ix
List of Tables	x
Chapter 1: Introduction	1
Chapter 2: Social Ecology Theories: Towards a Mental Disorder Approach	5
2.1 Introduction	5
2.2 Socioeconomic Stratification.....	6
2.3 Social Disorganization Theory	8
2.4 Routine Activities Theory	12
2.5 Integration of Mental Disorder in Social Ecology	15
2.6 Major Criticisms of Social Ecology Theories	21
2.7 Conclusions	24
Chapter 3: From Insanity to Uncertainty: The Development of Canadian Mental Health Law	28
3.1 Introduction	28
3.2 The Origins of the Insanity Defence	29
3.3 R. v. Swain	31
3.4 Bill C-30 and the Modernization of Mental Health Law	33
3.5 Orlowski v. British Columbia (Attorney General)	36
3.6 Winko v. B.C. (Forensic Psychiatric Institute).....	37
3.7 Conclusions	39
Chapter 4: Contextual Perspectives on Mental Health: A Review of Current Literature	40
4.1 Introduction	40
4.2 The Importance of Neighbourhood Characteristics	42
4.3 Experiences with Violence	44
4.4 Is Substance Abuse a Mental Health Issue?	48
4.4.1 Comorbidity of Mental Disorders and Substance Abuse	49
4.4.2 Social Relationships and Environmental Characteristics	52

4.4.3	Influence of Personality Disorders	56
4.5	Gender Differences	59
4.6	Policy Issues and Geographical Variations	62
4.7	Conclusions	68
Chapter 5: Methodology		70
5.1	Background.....	70
5.2	Issues of Study.....	73
5.3	Research Sample	74
5.4	Quantitative Methods - Data Collection.....	78
5.4.1	Demographic Information	78
5.4.2	Mental Health and Legal Background.....	78
5.4.3	Geography.....	79
5.4.4	Returns to Hospital	79
5.4.5	Review Board Decisions.....	79
5.5	Analytic Procedure	80
5.6	Data Concerns	81
5.7	Future Methodological Considerations - Qualitative Methods	83
Chapter 6: Results		86
6.1	Demographic Information	86
6.2	Mental Health History	94
6.3	Legal Status	96
6.4	Review Board Hearings.....	99
6.4.1	Conditional Discharge Orders	99
6.4.2	Review Board Decision-Making	101
6.5	Returns to Hospital	104
6.5.1	Time in the Community.....	104
6.5.2	Time in Hospital	105
6.5.3	Reasons for Return	106
6.6	Spatial Distribution.....	108
6.7	Neighbourhood Census Comparisons	115
6.7.1	Unemployment	115
6.7.2	Income	116
6.7.3	Poverty.....	116
6.7.4	Education	116
6.7.5	Rental Accommodation	117
6.7.6	Ethnic Diversity	117
6.7.7	Single or Unattached Occupancy.....	118
Chapter 7: Discussion		119
7.1	Consequences for Treatment	119
7.2	Proposals for Policy Making	121
7.3	Considerations for Urban Planning	125
7.4	Directions for Future Research.....	127
Chapter 8: Conclusions		133

Appendices.....	136
Appendix A: Conditional Discharge Orders	137
Appendix B: Community Boundaries for Lower Mainland Urban Areas	139
Appendix C: Zoomed Spatial Distributions for Conditionally Discharged NCR Accused	141
Appendix D: Census Choropleth Maps.....	142
Appendix E: Coding Sheets	147
Appendix F: Interview Instrument	152
Reference List.....	154

LIST OF FIGURES

Figure 1:	Cycle of Community Influence	72
Figure 2:	Locations of the Forensic Psychiatric Services Commission Outpatient Clinics and Inpatient Hospital	77
Figure 3:	Age of Admission to Forensic Psychiatric System	87
Figure 4:	Average Time on Conditional Discharge before Returning to Hospital	105
Figure 5:	Spatial Distribution – Areas of Residence at Admission	109
Figure 6:	Spatial Distribution – Areas of Residence upon Conditional Discharge.....	110
Figure 7:	Subsequent Address Changes 1999-2004	112
Figure 8:	Spatial Distribution: Sub-sample of NCR Accused Persons with 3+ Returns to Hospital – Movement Patterns of Residence by Individual Study Number	114

LIST OF TABLES

Table 1:	Admissions to Forensic Psychiatric Services after NCRMD.....	86
Table 2:	Sex of NCR Accused Sample (n=117).....	87
Table 3:	Marital Status at Admission.....	88
Table 4:	Living Arrangements at Admission.....	89
Table 5:	Cross-tabulation of Living Arrangements by Gender.....	89
Table 6:	Ethnic Background.....	90
Table 7:	Highest Educational Level.....	91
Table 8:	Employment Status at Admission.....	92
Table 9:	Financial Support at Admission.....	92
Table 10:	Housing Arrangement Prior to Admission.....	93
Table 11:	Psychiatric Diagnosis at Discharge (Multiple Response).....	95
Table 12:	Crosstabulation of Relation to Victim by Sex (Multiple Response).....	98
Table 13:	Under the Influence of Drugs or Alcohol for NCRMD Offence.....	99
Table 14:	Review Board Reasons for Judgment.....	102
Table 15:	Time spent in the community before returning to hospital (in months).....	105
Table 16:	Time Spent as Inpatient upon Return to Hospital (in days).....	106
Table 17:	Reasons for Return to Hospital (Multiple Response).....	106

CHAPTER 1: INTRODUCTION

Criminological research on mental disorder has a conventional focus on individual-level explanations for illness derived from the epistemologies of psychiatry and psychology. These perspectives explore the nature of mental illness as it is expressed in a clinical setting, through hospital populations and released outpatients. Under this guise, mental health rehabilitation is naturally interrelated with individual risk factors such as reduced symptoms, proper treatment compliance, and increased general insight into the illness (Douglas, Ogloff, & Hart, 2003; Banks et al., 2004).

However, these individual-oriented assumptions do not necessarily capture the full spectrum of influences on mental disorder, where people are in constant interaction with others who exert pressure over them and promote positive or negative changes in their lives. By situating an individual within their contextual environment, we are able to explore the effects of community structure and social interaction on the treatment of mental disorders. The social ecological approach, and more specifically social disorganization theory, alters the nature of the traditional concentration on psychological and biological explanations for mental illness: indeed, the approach builds on the preceding theories of individual motivations and biochemical impacts on behaviour by examining the role of these factors within a larger social and physical environment. These theories promote a direction for research on mental disorder that involves the interaction of the individual characteristics of psychopathology, the support of immediate social networks, and the communal space they occupy. This new understanding of the

complex interactions which exacerbate mental disorder in the community essentially synthesizes previous psychological and biological explanations of behaviour, yet also broadens their applicability to the development of contemporary forensic health policy.

Environmental criminology and mental health policy have primarily developed independent research relating to the crimes of various types of offenders, but the mentally disordered offender or the forensic patient is a natural bridge that connects these two fields. This research study combines the fields of environmental criminology with forensic mental health, and provides an exploratory view of how neighbourhood and community factors can influence the reintegration of forensic patients after they are released from hospital. Through the exploration of residential patterns of not-criminally-responsible-accused persons, we can ascertain the regions of British Columbia's lower mainland where these individuals reside, and can address the potentially advantageous or detrimental features of each community setting. The study focuses on the relationship between the geographic and socioeconomic characteristics of a community and the release patterns of the Not-Criminally-Responsible (NCR) accused.

Just as environmental perspectives are important for the holistic understanding of reintegration barriers, so too are they important for Review Board members who determine the legal dispositions of NCR accused persons. This project explores the extent to which the British Columbia Review Board considers environmental factors in their release decisions and examines the inclusion of contextual variables in conditional discharge orders. Review Boards hold ultimate legal authority over a conditionally-discharged NCR accused and, therefore, have the ability to include or disregard any information presented to them during the course of their hearings. Consequently, the

decision-making process of Review Boards is a critical factor in the determination of environmental influences in the community.

This study begins in chapter 2 with an exploration of social ecology theories as they were first conceived in the 1930s. An overview of original works by the Chicago criminologists is presented, especially as it relates to the development of social disorganization theory. Elements of routine activities theory are borrowed and combined with the social disorganization approach in order to provide an updated perspective on the traditional theoretical framework. Finally, these new theoretical constructs are applied to the field of mental health and the mentally disordered offender. The applicability of social ecology to the discipline of mental health is discussed and an outline is provided of the elements of the theories that were relied on for this study.

Chapter 3 examines the changes in mental health law that have occurred in Canada from original British law to modern legislative amendments. While the definition of mental disorder in law has remained fairly constant over time, the manner in which the criminal justice system responds NCR accused persons has evolved into a unique and complicated process. The specific legislation affecting these individuals is outlined in this chapter and the relevant Canadian case law is discussed.

A thorough review of the relevant literature is presented in Chapter 4, both in the areas of mental disorder and environmental influences. This exploration of recent and established scientific literature presents a synthesis of ideas concerning the external and internal influences on mental disorder, including the role of substance abuse, personality disorders, social networks, and violence. These factors are also examined for their differential impact on male and female mental health patients. By presenting a

comprehensive analysis of both mental disorder and environmental factors, the basis is laid for a deeper appreciation of the impetus for the present study.

The methods used to collect and analyse information for this research are presented in Chapter 5. The sample population is drawn from patients who were conditionally discharged from the Forensic Psychiatric Hospital in British Columbia during the years 1998 to 2003, and includes female and male subjects of varying ages. The specific procedures used for data collection are outlined and the analytical methods, that were utilized for both statistical analysis and geographic mapping, are fully described.

The results of the analysis and discussions on the impact of the findings are examined in Chapter 6 and Chapter 7 respectively. Chapter 6 presents an overview of the major features of the study sample, such as demographic background, psychiatric history, and legal status. It also presents an exploratory spatial analysis of the changing residential patterns of released NCR accused persons. Chapter 7 addresses the broader aspects of these findings and explores the implications for treatment, forensic policy, and future research.

This study is designed to promote a re-examination of the nature of forensic populations through a review of the external environmental influences that affect their lives. The chapters of this thesis provide an incremental progression through the areas of research that shape our view of this unique group of offenders, culminating in the results obtained from the analysis of the geographical release patterns and characteristics of not-criminally-responsible accused persons in British Columbia.

CHAPTER 2: SOCIAL ECOLOGY THEORIES: TOWARDS A MENTAL DISORDER APPROACH

Social disorganization is the herpes of criminology ... once you think it is gone for good, the symptoms flair up again. (Bursik & Grasmick, 1993, p. 30)

2.1 Introduction

This chapter examines the theoretical development of the social ecological approach, particularly as it relates to mentally disordered offenders. Prior to the development of social ecology theories, criminological thought had traditionally focused on individual and group behaviours as factors that contribute to crime in urban areas. Those theories which focused on the individual promoted a view of the criminal offender as a product of his or her own intrinsic deficiencies—meaning that there are aspects of the self that vary one's tendency towards the commission of deviant behaviour. Sociological explanations for crime emerged with a different explanatory perspective that considered an individual's interactions with social peers as a significant influence on criminality. While these criminological paradigms can provide substantial descriptive frameworks for understanding crime and criminal behaviour, they continue to avoid the encompassing theoretical aspect of situating an offender in their broader environment.

The discipline of Social Ecology can be seen as a product of the dissatisfaction with individual and social explanations for crime. It built on the preceding theories of individual motivations and social impacts on behaviour, but additionally examined those motivations and peer interactions within the context of the larger social and physical environment. Premised upon the early work of the Chicago School, these theories

promote an explanation for crime that involves the interaction of individuals, their immediate social groups, and the physical space they occupy. Essentially, this new analysis of the complex interactions necessary to generate deviant behaviour synthesizes the previous understandings of individual and social behaviour while broadening its applicability. The multifaceted problems of youth, urban centres, diminished wealth, and racial segregation are explored more fully with the inclusion of environmental trends and neighbourhood effects on criminality. However, while traditional social ecology theories are well versed in their explanations of crime with the above-noted demographic characteristics, relatively little theory has been developed in the realm of mental illness and environment. This review explores the ideological underpinnings of social ecology and environmental criminology while assessing its future application to the understanding of mentally disordered offenders.

2.2 Socioeconomic Stratification

The use of socioeconomic and class structures as a basis for analysing neighbourhood variation has a strong tradition within the discipline of Social Ecology. As such, it is important to understand how researchers developed their reliance on social, economic, and neighbourhood boundaries as important features of social organization and disorganization. As Sampson (2002) so eloquently described, there is the paradox in social disorganization research that high crime areas seem to be both organized and disorganized simultaneously, yielding a troubling coexistence of opposing forces in the same space. Traditional use of social disorganization theory has focused on the class structure of a community and its socioeconomic features appropriate measures by which to call it organized or disorganized. The stratification of individuals with different

socioeconomic backgrounds into urban neighbourhoods depends on their unequal access to rewards and resources in society (Eaton, 2001). Owing, in part, to this stratification, residents are thought to migrate into areas of a city based on their economic and social standing, thereby creating a marked variation in socioeconomic status by neighbourhood boundary. As Bursik and Grasmick (1993) suggest, local neighbourhoods can provide an important framework for the actions of the residents therein:

Residents of relatively high-status areas may attempt to protect the reputation of their neighbourhoods and the financial investments they have made in those areas by making it difficult for those with fewer economic resources to maintain homes in the community. [This] represents the efforts of local residents to regulate the nature of the activities that take place within the borders of their local communities...we assume that the capacity for such regulation is determined by the extensiveness and density of the formal and informal networks within the neighbourhood that bind the residents together as a social community. (p. 3-4)

Such structured resistance to unwelcome influences in a neighbourhood becomes especially relevant when exploring the spatial distribution of social service programs, mental health services, and drug abuse treatment centres that meet the needs of mentally disordered offenders. It has been theorized that some communities are concerned about having the highest concentration of housing and social programs while other areas of a city will have very few (Bursik & Grasmick, 1993). These authors have suggested that the residents of heavily-serviced communities are powerless to resist the introduction of programs catering to the homeless, mentally ill, or drug-addicted as a result of their impoverished relational networks. Without the social organization to publicly control the development of their neighbourhood, the residents remain in a community that is unable to eradicate the features of social disorganization and the ensuing programs that are built in these areas.

2.3 Social Disorganization Theory

The theory of social disorganization is based upon the idea that understanding environmental patterns will naturally lead to inferences regarding the causes of criminality in those regions. This is part of the greater theoretical construct of social ecology, but is specifically concerned with the demographics of a region that lead to general social disorganization. This social disorganization is described in terms of community cohesion towards a common goal:

Social disorganization and social organization are on opposite ends of a continuum and describe a neighborhood's capacity to exert control over inappropriate or illegal behavior within its domain. (Cantillon et al., 2003, p.322)

The above quotation defines the major feature of social disorganization: a community's ability to wield control over the behaviours that exist in its space, and to persuade those who live within a neighbourhood to conduct themselves in accordance with the community's norms of acceptable behaviour. It is an approach that regards a community as a system of associated networks, both formal and informal, whose associations are rooted in family life, personal socialization, and community expectations (Bursick & Grasmick, 1993). This community control need not be overt, but can take the form of informal social control and watchful guardianship. Social disorganization is particularly concerned with the locations of areas of low informal social control and the interactions between the individual and the characteristics of such communities. These interactions are entrenched in the social and economic background of the individual, so that the neighbourhood characteristics in themselves create opportunities and impetuses for potential negative behaviour.

One of the most influential studies for examining social disorganization was brought forward in 1942 by Shaw and McKay of the Chicago School of theorists to establish the basis for a study of the relationship between community disorganization and crime by means of an examination of juvenile offenders' locations of residence in urban Chicago. A model of ecological growth, the Concentric Zone Model, was borrowed from E.W. Burgess by these social ecologists and applied to the urban development of cities (Shaw & McKay, 1942; 1969). This model proposes that, in the absence of opposing factors, the city naturally forms patterns of concentric circles radiating out from the downtown area. The centre of the circle forms Zone I: the central business district and industrial area, then Zone II: the zone of transition or slum, Zone III: the working class homes, Zone IV: the residential zone or middle-class homes, and finally Zone V: the outer commuters beyond the city limits (Shaw & McKay, 1969). What this structure demonstrates is the ability to divide a city into geographical patterns that contain mutually exclusive social characteristics. These zones could be examined based on their distributions of ethnicity, age, poverty, cultural values, behavioural standards, prevalence of disease, and many other characteristics. Investigating these broader social patterns lent a new understanding to crime as a complex event—an interaction between offenders, their values, and their environment.

By researching the locations of the residences of delinquent boys, the Shaw and McKay study demonstrated the link between particular zones of the city and rates of juvenile delinquency. While their review used maps of Chicago divided into zones of square miles in order to present their findings, they still recognized the limitations of mapping methods as a basis for drawing inferences concerning the relationship of crime

to specific locations in the city. In discussing the roots of delinquent activity, Shaw and McKay (1969) explained:

These more distinctively human situations, which seem to be directly related to delinquent conduct, are, in turn, products of larger economic and social processes characterizing the history and growth of the city and of the local communities which comprise it. (p. 14)

Indeed, Shaw and McKay intended to demonstrate how crime was a normal response to the social, structural, and cultural characteristics of a community and that the occurrence of delinquency in geographic areas of the city could be explained as a natural response to the socially disorganized environment in which they live. This study was primarily interested in the delinquent groups of lower class youth who had committed offences and were living in the Chicago area. These delinquents could be mapped and assessed according to the concentric circle theory and patterns of community characteristics could be measured. Thus, a focus on the zone of transition (Zone II) in the Concentric Circle Model was paramount to their theoretical assumptions.

The zone of transition is characterized by a predominantly immigrant population, mostly rental properties, high rates of juvenile delinquency, and a stable population size (Shaw & McKay, 1969). While population size was relatively stable, the composition of the population was in constant flux. This zone is, therefore, usually sizeable: however, it is comprised of different ethnic groups with different social, structural, and cultural beliefs that show an outward mobility through the zones. As current residents leave and progress outward to more affluent areas of the city, the new wave of immigrants take their place in the zone of transition (Shaw & McKay, 1969). The idea of the zone of transition has been expanded in current research such as that of Quillian (2003), who

examined the idea of residential immobility in poor neighbourhoods. He found that residents of socially disorganized and poverty-stricken communities do not tend to mobilize into more affluent areas of the city. Instead, they are “entrapped...in moderately and extremely poor neighborhoods” and tend to re-enter these communities even if they have previously attempted to leave (Quillian, 2003, p. 244). Although these findings are in direct contrast to Shaw and McKay’s argument of outward mobility, one can see that the concept of neighbourhood and environmental effects on an individual’s behaviour is still apparent in research today. Under these conditions, criminal values are perpetuated and they replace conventional values that are present under conditions of social cohesion.

While the Chicago study is the seminal work suggesting an incorporation of environmental influence with criminal offending, the study lacks a detailed examination of the socio-environmental pressures that are said to produce crime. The explanatory power of immigration as a means to social disorganization had pertinence at the time of the Chicago study, but arguably has a more moderate effect on the ethnically diverse cities of the current era. Further, the concentric zoning of cities has limitations when examining an urban centre divided by natural barriers (e.g. waterways) or having multiple business districts. Subsequent studies have shown support for social bonds and peer associations as factors in neighbourhood level delinquency, but that these variables do not account for variation in delinquency between different neighbourhoods (Cattarello, 2000). These studies show that social disorganization theory in criminology has limitations, but the impact of the theory is seen in the plethora of social ecology theories that developed from it.

2.4 Routine Activities Theory

...poor people have a worse choice of places to live. As a result, they often end up living where crime is easier to carry out. (Felson, 1998, p. 35)

In the development of an environmental aspect to crime, researchers began to examine which elements were necessarily present for a criminal event to occur. More specifically, it was theorized that in order for crime to occur, three factors must intersect in the same temporal and spatial setting: the presence of a motivated offender, the existence of a suitable target, and the absence of a capable guardian (Felson, 1998). The identification of these three fundamental factors creates a model or formula for criminal events that combines previous assumptions regarding the importance of the social environment and the attractiveness of targets. This model has also been used to show the probability of criminal victimization that results when these three factors converge around a potential victim (Velez, 2001). By considering each of these variables separately, we can begin to see the crucial role that each one plays in the configuration of crime.

The initiating character in any criminal event need not merely be present at the location of a crime, but must have a motivation or rationale for committing a criminal act at that moment. In Felson's (1998) description of the motivated offender, he asserts that, while the motivations for crime will vary between individuals, each person will inevitably rationalize their own criminal behaviour using their own set of reasons. Potential offenders are presumably rational participants, who, like all rational actors, make decisions according to the philosophy of pleasure seeking and pain avoidance (Bentham, 1907 as cited in Felson, 1998). Unlike the traditional view of the pleasure-seeking principle as being the sole motivator to commit crime, the routine activities

approach has expanded this notion to show that the *interaction* of the motivated, rational offender with his or her surroundings is a more appropriate and explanatory view of motivation. These interactions are entrenched in the social and economic background of the offender, so that the neighbourhood characteristics in themselves create motivations for potential offenders. In Hannon's (2002) study on the motivating factors for crime, poverty was found to lead to social disorganization as a consequence of the disproportionate ratio of motivated offenders and a limited number of targets. Thus, poverty as a motivating social characteristic has the paradoxical effect of increasing the incentive for illegal behaviours while reducing the number of attractive, available targets. Similarly, Cantillon et al. (2003) noted that situations such as poverty and fluctuating residential populations have a negative impact on social organization and result in increased crime for these neighbourhoods. These studies demonstrate that there has been a recognition by scholars that decisions are made in the context of one's surroundings and are not exempt from the influence of peripheral motivators.

Another factor to consider in the precursors to the commission of a criminal offence is an increase in impulsivity as mediated by environmental factors (Lynam et al, 2000). This impulsivity is in effect a diminished process of rational decision-making. The impulsive offender is motivated by an immediate preference for pleasure, rather than the rational weighing and selection of pleasure versus pain. The question then arises regarding what elements of the environment are conducive to a motivated offender and how the interaction with these targets can procure criminal activity. While individual motivation and suitable targets are demonstrably important to the criminal event, there

still remains the issue of how certain targets become vulnerable at the time that they are selected, while others remain secure.

A motivated offender alone cannot produce a criminal action; there must be an interaction between an individual and a tangible goal through which the pleasure principle will be fulfilled. These criminal targets are not sought out through extraordinary methods, but are instead present in one's everyday routine activities (Brantingham & Brantingham, 1998). Immeasurable numbers of targets are encountered throughout the course of one's activities; however, the decision to turn these targets into crime targets is based in part on the motivation of the offender and in part on the characteristics of the target itself. This goal or target is selected based on its suitability for satisfying certain needs and based on the measure of its "value, inertia, visibility, and access" (Felson, 1998, p. 54-55). Restated, the target becomes more attractive when evaluating its potential street value (in the case of property offences) or personal value (in the case of violent victimization), its ease of obtainment, and its ability to be observed conspicuously. This target selection has also been shown to take place along the constructs of paths and known spaces within these routine activities (Brantingham & Brantingham, 1998). As seen through the process of selecting suitable targets, motivated offenders are necessarily involved in a dynamic relationship with their environment.

The final element necessary for a criminal event is the absence of capable guardianship over both the target and the behaviour of the offender. As described by Felson (1998), a guardian is "someone whose mere presence serves as a gentle reminder that someone is looking" (p.53). Under this construct, guardians need not be active in their crime prevention strategies; through their engagement in routine activities, they act

in a guardianship capacity inasmuch as they intersect with the activities of others. This broad definition of guardianship has been explored in numerous studies that attempt to disseminate what constitutes a guardian at the community level (Morenoff et al., 2001; Ross et al., 2001; Sampson et al., 2002). More specifically, the idea of the neighbourhood as a guardian has been researched in order to demonstrate how weak ties and high levels of privacy amongst neighbours is related to high levels of violence and homicide (Morenoff et al., 2001). This research shows that there is a relationship between the absence of guardians and the presence of higher violent crime, and that this relationship's catalyst is the social disorganization and low social bonding of the particular community. By removing community-level guardianship over offenders and targets, an essential function of crime control is abolished. It is argued that neighbourhoods characterized by disadvantage and crime are also lacking proper guardianship owing to mistrust and weakened social control mechanisms (Ross et al., 2001). Therefore, according to Ross et al. (2001), absent guardians are products of a socially disorganized community and have the effect of reducing neighbourhood-level crime control by leaving motivated offenders and suitable targets unchecked. The convergence of the three factors is thus facilitated and the essential crime elements of offender, target and guardian intersect.

2.5 Integration of Mental Disorder in Social Ecology

While the theoretical principles of the social ecology approach seem to provide an adequate basis for describing standard criminal processes, they are somewhat limited in explaining the actions of mentally disordered offenders. Since the focus of social ecology theories has been to integrate the offender with their contextual environment, little attention has been paid to different types of offenders who may not follow the rational-

actor model. Shaw and McKay's (1969) study on urban distribution of crime is one such study that virtually ignored this unique offender group. Mental disorder or insanity was indeed mapped and included as data for the study; however, it was presented alongside other social phenomena such as truancy, infant mortality, and tuberculosis (Shaw & McKay, 1969). While the inclusion of mental illness as a factor associated with delinquency is a forward-thinking approach to criminological theory, it is insufficient to group it with behavioural deviance and rates of disease. Mental illness should be considered as an important research variable for crime, not just a characteristic or gauge of social disorganization. However, what this data lacks in depth, it makes up for in its suggestive discourse. Shaw and McKay assert that, based on the significant relationship found between delinquency and mental illness, one can safely assume that "problems highly correlated with rates of delinquents...are, in fact, similarly associated with neighbourhood conditions" (p. 107). Therefore, suggestions for future research include exploring the hypothesis that mental illness is linked to neighbourhood conditions and incorporating it within studies on delinquency. Unfortunately, Shaw and McKay (1969) did not focus on this particular aspect of their analysis, and while the relationship between mental illness and neighbourhoods was deemed to be significant, it has been lost in the overall conclusions of their study. Furthermore, little research in this area has been developed since these initial findings.

As expected, the developments in social ecology theories have systematically excluded any mention of mentally disordered offenders. Environmental criminological theories do not specifically discuss this category of offender, even though it is of importance when looking at the differential motivations for criminal offending. Of utmost

importance to the environmental theories is their use of cognitive mapping in determining how potential offenders select their crime locations (Brantingham & Brantingham, 1984). However, the mentally disordered offender will necessarily have different cognitive abilities than other groups of offenders, and will inevitably have differing abilities for drawing on cognitive mapping skills. Environmental criminology has yet to provide an operational model for this unique group of offenders and will not be able to expand its theoretical paradigm until the current limitations are recognized.

Contrary to the proponents of environmental criminology, the routine activities approach has generated some preliminary research into mental illness and criminality. In his description of “Skidders¹”, Felson (1998) suggests that mentally ill individuals are more likely to be weak members of society based on their likelihood to “(a) fall into poverty or be left behind and (b) become participants in some crime role, especially as victims” (p. 40). This disabling view of mentally ill individuals as weak and destitute victims is indicative of the historical application of social ecology theories to the mentally disordered. Further analysis into the environmental level influences on the behaviour of mentally disordered offenders is ignored and they are examined only inasmuch as they help produce a socially disorganized neighbourhood by providing ample targets and inadequate guardianship. This limited application of social ecology theories must be expanded by broadening the concepts brought forward in both the social disorganization and routine activities approaches. In this way, the relationship between

¹ “Skidders” is a term used in social mobility research and studies of socio-economic class. Felson used this term to describe individuals with downward social mobility - that is people who were currently losing prestige by either decreasing their economic standing or decreasing their social class. Felson’s research includes the mentally ill as a group that is classified as “skidders” or downwardly socially mobile (1998).

the geographic and socioeconomic characteristics of a community and the crime patterns of mentally disordered offenders can be better understood.

In relating the idea of the motivated offender to mental illness, it would be inappropriate to look at only individual-level factors of motivation. This individualistic fallacy comes from explaining “individual-level outcomes...exclusively in terms of individual-level characteristics” (Valkonen, 1967 as cited in Silver, 2000b).

Psychopathology as an individual-level characteristic is not a motivation to crime in itself, but instead should be considered with respect to how it becomes a motivating factor when encountered in certain environmental contexts. Therefore, when incorporating mentally disordered offenders into the definition of motivated offenders, one should not ignore the influence of community structure on the course of mental disorder. Research in the realm of mental health should expand in the following way:

More generally, by ignoring community-level factors (as most studies of risk factors for violent behavior do), researchers run the risk of misestimating the main effects of individual-level risk factors. Greater awareness of the pitfalls of the individualistic fallacy should increase our understanding of the causes of violence. (Silver, 2000b, p. 455)

Examining the role of adversity and stress in intense situations is one such way to incorporate community-level factors into the motivated mentally disordered offender. Research has found that when negative events of extreme situations (such as adverse neighbourhood characteristics) are experienced by individuals suffering from psychiatric disorders like schizophrenia, major depression, and posttraumatic stress disorder, they effect negative changes in an individual’s goal-directed activities (Hollingshead & Redlich, 1958 as cited in Dohrenwend, 2000). Similarly, studies on violent victimization of the mentally ill have shown significant relationships with future violence, violent

crime, and substance misuse (Swanson et al., 2002; Hiday et al., 2001). This new research essentially alters our understanding of the motivations driving the mentally disordered offender. However, it is evident that the principle of the motivated offender is still relevant to the explanation of crime and the mentally disordered actor.

While the suitability of a target is not apparently altered by the application of the theory to mentally disordered offenders, there are issues limited to this group that need to be considered. In testing the hypothesis that psychopathology is associated with social isolation, Swanson et al. (1997) found partial support for the idea that social isolation is not only more prevalent for individuals with major mental disorder, but also reduces the number of available targets to the offender. This relationship was specifically examined with respect to violent targets, but could also theoretically be applied to a diminished interaction with property targets. The suitability of either category of target will also be influenced by comorbid mental health issues such as substance abuse (Swanson et al., 2002). Individuals suffering from psychological illness in combination with substance abuse may exhibit different target-seeking behaviour by searching for specific targets such as drugs and alcohol, which serve to reduce psychotic symptoms. Building upon previous research, Silver and Teasdale (2005) examined the combined effects of, among other variables, social isolation, mental disorder, and substance abuse. Their findings suggest that there remains a significant increase in risk for violence when an individual presents with both a substance abuse disorder and major mental disorder, especially when social support is lacking (Silver & Teasdale, 2005). Since social isolation and substance abuse appear to have such marked effects on the propensity towards violent behaviour, it follows that mentally disordered offenders will have outlets for this violence that may be

different than other offender groups. As such, the principle of 'target-selection' as outlined in the routine activities approach may be exercised differently in the behaviour of mentally disordered offenders.

The absence of guardianship is a principle that is most easily adopted into the conceptual model of the mentally disordered offender. There have been an increasing number of scholars who have built on the brief analysis in Shaw and McKay's (1969) research in order to incorporate neighbourhood-level characteristics in their studies of mentally ill individuals (Silver et al., 1999; Silver, 2002; Cutrona et al., 2000). These studies each indicate that neighbourhood-level features interact to influence individual-level violent and criminal behaviour. In particular, Silver (2000a) acknowledges that Shaw and McKay's social disorganization theory laid the foundations for the ideas of neighbourhood social control and guardianship but he builds upon these constructs to include mental disorder.

In extending social disorganization theory to account for variation in the violent behavior of individuals with mental illnesses, I suggest that, just as residents of socially organized neighborhoods are likely to act as guardians in attempting to control the behaviour of teenaged peer groups, so too are such residents motivated to control the threatening or otherwise disruptive behaviors of persons with mental illnesses (Silver, 2000a, p. 1048).

Therefore, the idea of guardianship being a factor in the criminal event is as much explained by individual-level guardians as it is by community guardianship. This community guardianship seems to be of utmost importance for mentally ill offenders since they are more likely to be in need of care and management in the course of their routine activities. The care and control they receive can also act as a protective role since interaction with a psychiatric treatment team provides a level of watchful guardianship

over the activities of the offender, thereby limiting an individual's access to crime targets. Swanson et al. (1997) showed that when a mentally ill offender has ongoing treatment in the community, they exhibit a significant reduction in violent behaviour. This demonstrates that the absence of guardianship for mentally disordered offenders may take a different form than the traditional model presupposes, but that the results of this absence are still increased opportunity for social disorganization, violence, and crime.

2.6 Major Criticisms of Social Ecology Theories

Many criticisms of the social ecological perspective have emerged within the discipline of criminology, although none as poignant as the quotation from Bursik and Grasmick (1993) at the beginning of this chapter. Social disorganization theory has been limited by the era and location in which it developed: 1930s and 1940s Chicago, when immigration was high and community values and norms were arguably compared with those of a white, middle-class, suburban majority. These normative assumptions were not overt aspects of the theories, but instead reflected the definitions of an organized or disorganized community. As Mills (1994) said:

The pathological or disorganized is the maladjusted. This concept, as well as that of the "normal", is usually left empty of concrete, social content, or its content is, in effect, a propaganda for conformity to those norms and traits ideally associated with small-town, middle-class milieu. (p.81)

Sampson (2002) has clarified that the normative structure of most interest to social disorganization is not a class-bound or culturally-bound definition of "normal", but rather a desire for community residents to live in a safe and orderly environment that is free from predatory crime. Through this reformulation, it can be argued that there are some aspects of social norms that are universal and are not influenced even by cultural

boundaries. Nevertheless, the foundations of the social ecological perspective, through the works of Shaw and McKay among others, will continue to be interpreted with scepticism owing to their reliance on ethnic diversity and poverty as correlated variables for areas of crime and deviance in cities.

Additionally, these perspectives have relied—and continue to rely—on neighbourhood boundaries as significant indicators of social ecological environments. While these units of measure are meaningful when using census-collected data, the attribution of social meaning to areas that were divided for the purpose of government data collection and land zoning does not necessarily reflect a true and natural division of community types. Researchers in this framework have consistently supported the idea that neighbourhoods are in fact ecological units that are naturally formed (Sampson, 2002); however, the fluctuating boundaries of communities and social factors, such as zoning regulations, social influence, and political decision-making, continue to underscore the importance of evaluating the underlying assumptions of social ecology as an explanatory theory. Neighbourhoods are malleable and changing; they are not independent of the influence of the greater communities around them, especially over time. It is important to recognize that the naturally occurring zones of Chicago, which were instrumental in the formation of social disorganization theory, do not necessarily maintain their boundaries in the same locations as in 1942 and are not necessarily composed of the same demographic groups as in the seminal research of Shaw and McKay. In fact, a test of the theory in England and Wales provided support for the distinctive influence of lower-class communities on youth crime but did not find the same ethnic distinctions as the original theory (Sampson & Groves, 1989). Even though many

community influences are noted by Sampson and Groves (1989), they recognized the limited generalizations that could be made from neighbourhood effects.

Beyond the definition of neighbourhoods and communities, social ecology has had difficulty explaining the operational differences between social organization and disorganization. Indeed, it has been the acceptance of this term “disorganization” or deviation from the norm that has drawn a significant amount of resistance from other social science researchers (Bursik & Grasmick, 1993; Mills, 1994; Sampson, 2002). This term is especially problematic when examining communities that may exhibit the standard features of social disorganization such as fluctuating population, high poverty, high crime, etc. but which are organized in terms of social networks, community ties, or neighbourhood-level influence over the activities of its residents. References to the state of American housing projects and ghettos have been used to describe neighbourhoods such as these (Anderson, 1978 as cited in Sampson, 2002). From a census perspective, these project communities are often infused with poverty, crime, and ethnic and migrant populations, yet many of these areas demonstrate a clear code of conduct and community control over the behaviour and activities of the residents therein. There is an organization to many traditionally socially disorganized areas that is not fully explored by researchers from this ideology. A broadening of the term ‘social disorganization’ is needed in order to show that social disorganization is not chaos nor is it the lack of social ties. Clearly communities can be organized with respect to some features (i.e. social networks) while still not working towards the collective goal of controlling deviant behaviour (Sampson, 2002). Under this reformulation of the theory, a resolution to this long-standing criticism may be possible and researchers can acknowledge both the simultaneous organization

and disorganization in communities. In this way, it is important to build upon the foundations of traditional social ecology theories with more current and varied research applications, in order that the influence of community-level variables continues to be examined in new and novel ways.

2.7 Conclusions

The social ecology theories have traditionally followed the principle that, in order to understand the criminal event, one must understand offenders in the context of their environment. While this tenet appears to examine the entire criminal event, it applies an unfair and overly broad assumption that all offenders are fundamentally equal. Social ecology and environmental theories are bound by the construct of every offender being equally rational and weighing their decisions on the scale of pleasure and pain. This theoretical construct has limited the applicability of these theories since it does not account for the intricacies of the human experience nor the multi-layered motivations that drive individuals toward criminal behaviour. This is best exemplified by the minimal attention that has been given to mental disorder and its effects on criminality within the social ecology theoretical realm. Elements of mental disorder and cognitive impairment are also incongruent with the basic tenets of learning theories and rational choice theories, that assume all individuals have equal abilities to reason and learn. It is not a matter of these theories being unrelated to mental health; it is merely that mental illness (and the often accompanying neuro-cognitive impairment) has been ignored as a defining feature of certain offenders.

Irrespective of the limitations outlined for these theories, the Social Ecology perspective has maintained a strong and influential presence within the larger body of

general Criminological theory. It is under this theoretical realm that explanations of crime and place are offered; providing a significant departure from the focus on individual behaviour or group behaviour that has often dominated crime theory. By comparing human criminal and non-criminal interaction to an ecological system, Social Ecology addresses both demographic/ethnographic variations in behaviour and the accompanying spatial distributions of those variations. Through such diverse sub-theories as social disorganization, routine activities, and environmental criminology, the discipline of Social Ecology directs research away from how an individual's inherent qualities or social circle influences their propensity toward criminal behaviour, and concentrates instead on the illegal activities that stem from a person's routine activities or along their known pathways (see Felson, 1998; Brantingham & Brantingham, 1984). It adds the third criminological dimension of 'place' to criminology's understanding of 'individual' and 'group' origins of illegal behaviour.

Similarly, the social ecology theories promote some alternative approaches to social control that are not seen in other areas of Criminology. In order to address crime or objectionable activities that are occurring in a particular place, Social Ecology suggests manipulating the opportunities for such behaviour through environmental restructuring (Bursik & Grasmick, 1993). These theories offer the idea that, just as individuals can be risk managed by changing aspects of their lives, so too can neighbourhoods and places of crime be supported or altered by people's investment in those spaces. As such, the discipline of Social Ecology provides an alternate rationalization for criminal events and deviant behaviour than is brought forward by other theoretical fields in Criminology.

Support has been shown for the broadening and modification of the social ecology theories in order to better account for this unique aspect of mental illness and criminality. Ross and Mirowsky (2001) have suggested that the health of residents, including their mental health, may be affected by neighbourhood disadvantage over and above the effects of personal disadvantage. This finding broadens the scope of the social ecology theories, by incorporating neighbourhood or environmental factors as explanations for changes in mental disorder. Building on this idea, research has begun to examine the gender differences in reactions to stressful events, and to apply the sociological model in combination with the medical model when exploring issues of mental illness (Aneshensel et al., 1991). Gender issues and their impact on the motivated offender, target selection, and differences in guardianship are under-explored in the social ecology theories especially when combined with mental disorder. Future developments in this area are needed in order to broaden the social ecological explanations of crime. Individual-level characteristics can be incorporated into the definitions of a motivated offender, so that psychopathologies and severe symptomology are acknowledged as contributing to the differences in motivation and behavioural self-control of the mentally disordered offender. Target-seeking behaviour differences have not been fully explored and possible variations in the choice of targets are also under-researched. However, it is in the field of guardianship and neighbourhood-level characteristics of social control that the domain of mental illness can be best incorporated.

Guardianship and mentally disordered crime can be integrated through the combination of individual and aggregate-level characteristics of offending. Kubrin and Weitzer (2003) suggest that the new role for social disorganization and social ecology

theories is exactly in this area, with particular focus on “the degree to which people exercise social control in their neighborhoods” (p. 375). This level of community guardianship is especially appropriate with mentally disordered offenders since their individual-level controls may be different from standard offenders. Research into guardianship in the community examines these aggregate characteristics and relates their impact to the individual behaviour of mentally disordered offenders. Studies addressing the lack of guardianship in social ecology have typically focused on the informal social controls of the community, but there is room for growth in relation to the interaction of formal controls with informal controls whose collective presence can act as a guardian (Kubrin & Weitzer, 2003). This suggestion for enlarging the definition of guardian is especially relevant for mental illness since the formal social controls are often community treatment teams and outreach workers. Consequently, a complete understanding of mentally disordered criminality can not be created without addressing Silver’s (2002) recommendation that research is needed in the area of situational and interpersonal circumstances that lead mentally disordered offenders to violent and conflicted social relationships. These situational and interpersonal characteristics should be applied to existing social ecology principles, so that these theories may be influential in mental health policy and will improve our understanding of the potential environmental influences on this unique group of offenders.

CHAPTER 3: FROM INSANITY TO UNCERTAINTY: THE DEVELOPMENT OF CANADIAN MENTAL HEALTH LAW

3.1 Introduction

The legacy of the social disorganization and urban planning movement in criminology has been the recognition that factors outside of an individual's freedom of choice may play into their potential criminality. Researchers in the field of social ecology had begun to explore mental disorder as a contributing factor to social disorder, but had limited their inquiry to the study of urban influences on the distribution of psychotic illnesses. Studies of this type are limited by the definitions of mental disorder that were articulated during the first half of the twentieth century - especially, the definition of insanity that was developed by the Canadian courts when they applied the so-called insanity defence under the relevant provisions of the *Criminal Code*. These sections of the law delineated the circumstances under which mental disorders would be recognized as a contributing factor to criminal actions and the processes by which they would be handled in the criminal justice system. As such, the insanity provisions in criminal law guided the way in which mental disorders were included in criminological research. It is, therefore, important to examine the evolution of mental health law, especially as it relates to the release of forensic patients into the community, so as to understand the potential influence of the community on this specialized classification of criminal offenders.

3.2 The Origins of the Insanity Defence

As with all Canadian criminal law, the development of the insanity defence and subsequent criminal consequences can be traced back to its roots in English statutes and common law (Verdun-Jones, 1979). The concept of being acquitted for reasons of insanity was first recognized in 16th century England (Ogloff et al., 2000), creating a precedent that a mentally disordered individual could lack a ‘guilty mind’ as required for the doctrine of *mens rea*², thereby removing that individual’s criminal responsibility. The removal of criminal responsibility on grounds of insanity was further solidified in 1843 when the defendant Daniel M’Naghten used the defence successfully after his assassination attempt on the Prime Minister of Britain (Verdun-Jones, 1979; Ogloff et al., 2000). Under this court’s decision, the cognitive test for insanity was formalized, reflecting a focus on the thought process needed to advance the defence successfully. In what came to be known as the *M’Naghten rules*, the trial court ordered that every person is to be considered sane unless:

At the time of the committing of the act, the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know he was doing what was wrong. (*R. v. M’Naghten*, 1843)

These rules as outlined in *M’Naghten* evolved into more detailed and sophisticated provisions in criminal law, but the main guise of the cognitive test of insanity was—and still is—rooted in this case. Canada adopted the M’Naghten rules into the *Canadian Criminal Code* in 1892 and they remained relatively unchanged until 1992.

² Under criminal law, two elements must be present for an individual to be held responsible for the action under question. The first is the presence of *actus reus* or the criminal act. A person must have caused the criminal event or acted in such a way that they committed a criminal offence through either their action or through an omission. Additionally, there must be the element of *mens rea* or a guilty mind. The criminal actor must be able to recognize the potential consequences of their actions and to know that their actions were morally wrong.

Laid out in s.16 of the *Criminal Code*, these rules for the insanity defence specified the criteria needed for a Canadian court to recognize insanity as a condition that should result in an accused person being exempted from criminal responsibility. Until 1992, s.16 remained unchanged in the following form:

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.

The insanity rules as outlined in s.16 followed the basic standard of the M'Naghten rules, with some expansion in the definition of insanity under the law. Although somewhat detailed in their discussion of delusions, natural mental impairments, and other psychiatric states, these standards have created significant difficulties for the courts that have been required to apply the insanity defence (Ogloff et al., 2000). This is in part a result of the very significant consequences that occurred when the defence was raised successfully. Under these *Criminal Code* provisions, individuals who were found not guilty by reason of insanity (NGRI) were detained in a facility for an indeterminate amount of time automatically upon the court's judgment. This automatic detention lasted until such time as the Lieutenant Governor decided that the individual no longer needed to be held in custody in a psychiatric institution. Review tribunals existed to periodically review a case and make a recommendation to the Lieutenant Governor about the

disposition of a patient; however, the true power of release decision-making rested with the provincial or territorial government . Based in part on the recognition of the outdated mental health law and in part on the emerging *Charter* challenges to the existing insanity provisions, the House of Commons brought forward a legislative bill that would drastically change the scope of mental disorder in Canadian criminal law.

3.3 R. v. Swain

This case presented, among others, s.7 and s.9 *Charter* challenges to certain mental disorder provisions of the *Criminal Code*. Specifically, the Supreme Court of Canada considered the possible *Charter* infringements of s.614(2), the section requiring an accused person who was found not guilty by reason of insanity (NGRI) to be kept in strict custody at the pleasure of the Lieutenant Governor (Verdun-Jones, 1994). Of particular consideration in this case were the rights afforded to an NGRI acquittee who did not require custodial care for reasons of health or safety, and for whom detention in a psychiatric facility upon being acquitted was not necessarily the most appropriate judicial response. As a result, the court held that the mental disorder provisions in section 614(2) violated an individual's s.7 *Charter* rights regarding life, liberty, and security of the person, and that it violated an individual's s.9 right against arbitrary detention by providing for the automatic indefinite detention of an NGRI acquittee under a Lieutenant Governor's warrant (*R. v. Swain*, 1991). Neither of these *Charter* violations could be saved by s.1 as a reasonable limitation on the rights of the accused person (Verdun-Jones, 1994).

The *Criminal Code*, as it was in 1991, did not provide for any process by which an accused could appeal their detention to the courts: therefore, an NGRI accused could

not challenge the Lieutenant-Governor's warrant under which he or she was being held. That is to say, an individual being held in custody at the pleasure of the Lieutenant Governor did not have access to an appeals court to review their order if they felt they no longer posed a threat to society and could properly be managed outside of a facility. The Supreme Court of Canada recognized this problem in *Swain* through their discussion of the blanket assumption of dangerousness in the legislative framework at the time. They state:

The assumption that persons found not guilty by reason of insanity pose a threat to society may well be rational but is not always valid. Not everyone acquitted by reason of insanity has a personal history of violent conduct and such conduct and previous mental disorder does not necessarily indicate a greater possibility of future dangerous conduct. (*R. v. Swain*, 1991)

The Court in *R. v. Swain* acknowledged the lack of procedures for safeguarding against improper custody orders and helped to spearhead the idea that automatic, indeterminate detention was not the only way of managing NGRI accused persons. Their acknowledgement was also one of the leading motivations for reformulating the mental disorder provisions of the *Criminal Code* to include an expanded role for existing review tribunals (Snell, 2000). The court in *Swain* suspended the operation of its judgment for 6 months in order to give the Canadian government enough time to formulate new legislation that would encapsulate the *Charter* challenges and decisions as discussed by the Justices. These ideas, among others, were formalized into parliamentary legislation and brought forward as Bill C-30 in 1991.

3.4 Bill C-30 and the Modernization of Mental Health Law

In late 1991, the House of Commons of Canada introduced Bill C-30, *An Act to amend the Criminal Code (mental disorder) and to amend the National Defence Act and the Young Offenders Act in consequence thereof*, which was reviewed and enacted in 1992. This piece of legislation clearly enumerates the goal of rewriting the mental disorder provisions of the *Criminal Code* and explains which issues are particularly noteworthy to the operation of the criminal justice system. Specifically, it states:

The object of the amendments is to modernize, clarify, and streamline the law and procedure with respect to the mentally disordered accused, bearing in mind the rights of the accused under the *Canadian Charter of Rights and Freedoms* and the need to protect society. (p.i)

It is the specific focus on the *Charter* rights of the mentally disordered accused that diverges so markedly from the original insanity clauses of the *Criminal Code*. In particular, the new Bill amended the insanity defence and the procedures surrounding NCR accused who are unfit to stand trial, while attempting to balance the needs of public security with the treatment rights of the accused. Under the provisions of Bill C-30, section 2 of the *Criminal Code* was redefined to describe “mental disorder” as a disease of the mind, thereby codifying existing case law applications of mental disorder or insanity defences into a formal legislative framework. The use of the term ‘mental disorder’ as opposed to ‘insanity’ is demonstrative of the desire to modernize and humanize the treatment of mentally disordered accused persons, by focusing attention on the treatable disease of the mind rather than on the caricatured ‘insane’ or ‘naturally imbecilic’ person whose automatic or indeterminate hospitalization was required for the safety of the public.

Included in the new mental disorder provisions was the re-writing of s.16 of the *Criminal Code* and the introduction of the defence of mental disorder. While Grant (1997) has suggested that the changes were largely cosmetic, this defence reworked the wording of the insanity defence, while taking into account the newly defined term of mental disorder.

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.

The introduction of s.16(1) thereby eliminated the acquittal on the grounds of insanity and substituted it with a verdict of non-responsibility (s.672.34), where an accused committed the act or made the omission but is not criminally responsible for his or her actions on account of mental disorder (Verdun-Jones, 1994). The accused had to have experienced a mental disorder (or “disease of the mind”) that affected his or her judgment *at the time of the offence* in order to successfully raise the defence of not criminally responsible on account of mental disorder (NCRMD). It is recognized within the confines of this defence that the accused committed the criminal action or performed the *actus reus* for the offence, but the defence carefully outlines that the individual did not have the necessary capacity to be able to recognize that his or her action or inaction was morally wrong. This lack of appreciation for the nature and quality of the criminal act must originate from a mental disorder in order for the defence of NCRMD to be brought forward.

In addition to the new definition of the defence of mental disorder, Bill C-30 also changed the placement of the burden of proof for the mental disorder defence—placing it

on the party that raises the issue of mental disorder, whether that is the Crown or the defence. This new section allows for Crown to raise the issue of mental disorder when it believes that it reflects the best interests of the case. This proof of mental disorder is decided on a balance of probabilities; that is, it is presumed that an accused is either not mentally disordered whatsoever or that they are not impaired enough by their mental disorder that the court should remove criminal responsibility.

Of utmost importance to the new legislation was the proposal for an expanded role for current review tribunals under s.672.54. This changed them from an advisory position to a decision-making board that would have the primary decision-making role in relation to the detention and release of NCR accused persons. Under this proposed change, Review Boards rather than the Lieutenant Governor would make decisions concerning the disposition of NCR accused persons. In addition to no longer being held at the pleasure of the Lieutenant Governor, NCR accused were not automatically subject to custody in a psychiatric facility. Instead, Review Boards (or in some cases the trial courts) would now be able to decide between three possible dispositions to replace automatic indeterminate detention: absolute discharges, conditional discharges, and custodial orders. The criteria for such decisions are discussed at length in the legislation that was enacted in 1992; however, the wording of this section, along with the unclear definition of dangerousness as a criterion for release, has been one of the most pervasive and contentious repercussions of the legislative changes. It is only through the case law that followed the 1992 amendments that the scope of difficulties with the new mental disorder provisions truly began to develop.

3.5 Orlowski v. British Columbia (Attorney General)

One of the seminal cases in the understanding of the new *Criminal Code* amendments for mental disorder was the judgment of *Orlowski v. British Columbia (Attorney General)* (1992). In this decision, the British Columbia Court of Appeal clarified the issue of Review Board release criteria with specific focus on the definition of ‘significant threat’. As it is written in s.672.54 of the *Code*, in order for the Review Board or court to consider the disposition of an absolute discharge after a finding of NCRMD, the reviewing body must be convinced that the accused is “not a significant threat to the safety of the public”. However, it remained unclear as to the disposition that should be made if the Review Board or court was unsure about the level of threat posed by an NCR accused. The court held that if there is doubt about an accused person’s likelihood of presenting a ‘significant threat’, the reviewing body is not obliged to order an absolute discharge. In essence, the board or court must be certain about the absence of a significant threat in order to discharge absolutely; if they are uncertain about presenting a significant threat, they must choose between a discharge on conditions or a custody order. The *Orlowski* decision also differentiated between the categories of threat and significant threat (Grant, 1997), although it has remained unclear as to what features distinguish these two levels of dangerousness. Review Boards followed the test of significant threat when deciding whether or not to release an NCRMD accused, and in alignment with case law, erred on the side of caution by keeping patients on conditional or custody orders when unsure of their dangerousness or ‘significant threat’. While it was only a binding precedent in BC, the guiding principles for Review Boards outlined in *Orlowski* remained

strong as the correct interpretation of the new legislative changes until challenged in 1999 in a British Columbia court.

3.6 Winko v. B.C. (Forensic Psychiatric Institute)

The case of *Winko v. B.C. (Forensic Psychiatric Institute)* (1999) drastically changed the decision-making authority of the provincial Review Boards by providing a new interpretation of s.672.54 as it relates to dispositions and dangerousness. Joseph Winko was found NCRMD by a court in British Columbia and had spent numerous years under the order of the BC Review Board. A *Charter* appeal was brought forward in 1999 to the Supreme Court of Canada which both clarified the interpretation of s.672.54 of the *Criminal Code* and rejected a *Charter* challenge to this provision. Of most pervasive influence in *Winko* is the statutory analysis of s.672.54 surrounding the choice of dispositions available to courts and review boards. In the words of Justice McLachlin,

Properly read, s.672.54 does not create a presumption of dangerousness and does not, in its effect, impose a burden of proving lack of dangerousness on the NCR accused. The introductory part of s. 672.54 requires the court or Review Board to consider the need to protect the public from dangerous persons, together with the mental condition of the accused, his or her reintegration into society, and his or her other needs. The court or Review Board must then make the disposition "that is the least onerous and least restrictive to the accused". Under s. 672.54(a), the court or Review Board must direct that the accused be discharged absolutely if it is of the opinion that "the accused is not a significant threat to the safety of the public" ... Read in this way, it becomes clear that unless it makes a positive 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. (*Winko v. B.C. (Forensic Psychiatric Institute)*, 1999, para iv)

As such, the court in *Winko* reversed the judicial decision of *Orlowski* by requiring that an absolute discharge be ordered when there is doubt about an NCR

accused's dangerousness. As of the date of this decision, Review Boards may only consider a conditional discharge or custodial order if they are certain that the accused does indeed present a significant threat to society. If they are uncertain about an accused's likelihood for becoming a significant threat to society and cannot come to an affirmative finding of dangerousness, the Review Board must discharge the individual absolutely. The impact of the *Winko* case on dispositions of NCR accused persons is still being examined across Canada, but preliminary findings show that there has been an increase in absolute discharges granted after the decision of *Winko* (Balachandra et. al, 2004; Livingston et. al, 2003). This would be congruent with the premise that the Review Board must release an individual absolutely if they are in doubt of their threat to society. Similarly, the application of the least onerous and least restrictive disposition, as outlined in *Winko*, applies not only to the three choices of absolute discharge, conditional discharge, and custody order, but also to the compilation of conditions that are imposed on an NCR accused person by the Review Board or Court. These conditions are present with both custody orders and conditional discharge orders, thereby reiterating the frequency with which reviewing bodies must consider the complexity and restrictiveness of imposing certain conditions (see *Penetanguishene Mental Health Centre v. Ontario (Attorney General)*, 2004; *Pinet v. St. Thomas Psychiatric Hospital*, 2004). It will be important to continue monitoring and building research around the impact of this case, as it has significant consequences to the number of former forensic patients in the community.

3.7 Conclusions

While legislative and common law changes have been slow in the area of mental health law, Canada has seen a more marked evolution with the introduction of Bill C-30. Though the impact of these amendments have been wrought with different interpretations of the new mental disorder provisions, especially with regards to the application of a threshold of significant threat, they are nonetheless an important backdrop for the proper understanding of forensic psychiatric services in Canada. Cases such as *Orlowski* and *Swain* serve to demonstrate that, although mental disorder may be restructured on a judicial level, substantial implications still exist for the practical application of these important decisions. These implications include potential remedies to some of the issues arising from former forensic policy, such as the indeterminate custody orders that existed pre-1992. However, court decisions on the interpretation of the mental disorder provisions can also have unintended repercussions for the clients who are currently involved in the forensic system. With potentially increasing numbers of forensic patients being discharged into the community either absolutely or under conditions, it is timely to examine the prospective environmental influences that may impact their successful reintegration into society. As such, we will be able to examine a new aspect of the consequences stemming from the changes in mental health law and forensic policy.

CHAPTER 4: CONTEXTUAL PERSPECTIVES ON MENTAL HEALTH: A REVIEW OF CURRENT LITERATURE

4.1 Introduction

Severe psychiatric symptoms have traditionally been understood in the context of individual-level pathology and distinct motivations for behaviour. Restated, psychology and psychiatry are equipped to examine mental health on an *individual* basis, with each patient evaluated based on standardized criteria. These criteria are usually drawn from the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IVTR)* or other similar diagnostic manuals that confirm the symptoms of a mental disorder in order to properly complete a diagnosis. While these methods are successful in determining a label for the category of mental disorder that afflicts a patient, they are not comprehensive enough to encompass all the information that may influence the course of an individual's illness.

Complete reliance on diagnostic labels limits our understanding of severe forms of mental illness, but is most restricting for those suffering from major mental illnesses who are released from hospital care into the community. Many issues emerge for this population that cannot be addressed with a standardized diagnosis since these difficulties may only appear contextually or may vary based on length of treatment. Of special concern to these patients is access to, and use of, community treatment facilities, compliance with medication, and violence. Violence is a unique variable in mental illness since patients are both at risk of violent victimization and for perpetrating violence on others (Hiday, 1995; Hiday 1997; Silver, 2000a). While these factors alone can have

profound effects on successful re-integration into a community setting and maintenance of adequate mental health, they are further confounded by the complicating factor of substance abuse. Abuse of drugs and alcohol varies in its severity, from recreational use, to a health risk, to an addiction. Those with the heaviest use are at highest risk for ‘dual diagnosis’ (Rachbeisel et al., 1999); a secondary diagnosis of drug or alcohol dependence further to their diagnosis of a mental disorder on the DSM-IVTR. Beyond this second diagnosis, substance abuse has a complex relationship with severe mental illness that affects an individual’s level of functioning in the community (Mowbray et al., 1997). In general, the relationship is unfortunately detrimental to the success of mental health treatment and further exacerbates problems with medication compliance, treatment, and violence.

Social disorganization literature has looked at the effects of community variables and major mental disorder together. This perspective posits that the community in which a person operates exerts some level of influence over their various behaviours. This influence is noteworthy in areas of high social disorganization—where violence, mental disorder, and substance abuse are potentially more common and more visible. The multifaceted problems encountered by the severely mentally ill—including unemployment, homelessness, isolation, and experiences with violence—are more fully explored through the inclusion of environmental factors and neighbourhood effects. The intent of this chapter is to analyze the current academic research that has been conducted in the area of social disorganization and mental disorder, with specific attention to its effects on individuals with mental illness living outside of custodial care. This will include a discussion of the role of community characteristics, violence, and substance

abuse on mental disorder and an examination of how these characteristics are experienced differently by male and female clients. Finally, literature regarding geographic influences on mental health policy will be considered in order to emphasize the role that social ecology and urban planning concerns can play in mental health.

4.2 The Importance of Neighbourhood Characteristics

While traditional applications of social disorganization literature do not discuss mental disorder in relation to criminality and social control, there is a growing field of research that incorporates neighbourhood-level characteristics with mentally ill individuals (Silver et al., 1999; Silver, 2002; Curtona et al., 2000). In particular, Silver (2000a) acknowledges that Shaw and McKay's social disorganization theory laid the foundations for the ideas of neighbourhood social control and guardianship but builds upon these constructs to include mental disorder. This special population seems particularly well accounted for by explanations of social disorganization and social guardianship, since contextual factors of disorganization and discrimination present new perspectives for understanding community reintegration. There is a stigma that accompanies mental illness, related in part to the symptoms of the illness being visible through behaviour and in part to the negative stereotypes of violent mental patients that sway public attitudes about the mentally ill (Arboleda-Florez, 2003). The reaction of community members to the mentally ill shapes the features of acceptance in a neighbourhood and can be directly related to the levels of social support that will be available to a patient. Evert et al. (2003) have shown that people with mental illness experience greater degrees of social isolation and that this isolation is especially prominent for those who are living in marginal accommodation. Since low income and

inadequate housing is a feature of a socially disorganized neighbourhood, it is reasonable to assert that patients' social networks are likely to be small and, therefore, provide little support or influence on their guardianship.

The threatening environment of socially disorganized areas may mediate relationships and social networks in the lives of the mentally ill. Examining the role of adversity and stress in intense situations is one way to incorporate community-level factors into research that is focussed on the mentally disordered individual. Most recently, a study by Silver and Teasdale (2005) compared the role of stressful life events and social support in the relationship between mental disorder and violence. Their results showed that both stressful events and impaired social support were independently and significantly positively associated with violence in their sample. Further, their model of statistical association confirmed that the presence of both stressful life events and impaired social support increase the probability of also experiencing a major mental disorder or a substance abuse disorder (Silver & Teasdale, 2005). Dohrenwend (2000) found that, when stressful events from extreme situations (such as adverse neighbourhood characteristics) are experienced by individuals suffering from psychiatric disorders like schizophrenia, major depression, and posttraumatic stress disorder, they effect negative changes in an individual's goal-directed activities. Similarly, such volatile community features of crime, harassment, danger, and isolation have been shown to weaken the physical and mental health of residents, most notably in regions of social disorganization (Ross & Mirowsky, 2001). This connection to health was found irrespective of the level of social contact and support that was available to the individual subjects. The studies each indicate that neighbourhood-level features interact to influence individual-level

violence and mental health. Therefore, the idea of guardianship and community control playing a role in the mental disorder is as much explained by an individual's support network as it is by community guardianship. Community guardianship seems to be of utmost importance with mentally ill offenders since they are more likely to be in need of care and management in the course of their routine activities. In this way, Swanson et al. (1997) have shown that there is a significant reduction in violent behaviour when a mentally ill individual has ongoing treatment in the community. This treatment involves interaction with people who exert influence over a patient and become a member of their social network. However, social contact can be either an advantage or disadvantage for the mentally ill. It can provide support in a life characterized by social disorganization, or more opportunity for violent interaction and violent victimization.

4.3 Experiences with Violence

Initial studies into the domain of social ecology and neighbourhood disorganization have tended to focus on mental disorder and the environment as it produces a suitable setting for victimization (Hiday, 1995). Hiday (1997) theorized that the strain produced by disorganized social environments is influential in the link between violence and individuals with major mental disorders. This idea was expanded in her subsequent study on victimization, which found that a particular social stressor, criminal victimization, was a significant factor in mentally disordered offenders resorting to violence and violent crime (Hiday et al., 2001). These studies imply that individuals with major mental disorders are likely to be involved in violent social relationships that in turn provoke violence. Rates of violence are significantly high for individuals suffering from mental illness, with some studies showing these individuals presenting up to four times

the risk of violence compared to the general population (Angermeyer, 2000). This violence and victimization seems mediated by other factors alongside conflicted social relationships, such as the threat-control-override symptoms associated with paranoia. Angermeyer's (2000) study of subjects suffering from schizophrenia shows that paranoid and psychotic symptoms are closely related to levels of violent behaviour, while research by Hiday et al. (2002) identified homelessness, substance use, paranoid symptoms, and previous victimization as all being significantly correlated with further violent victimization. These studies show an overlap in the relationship of internal psychotic symptoms with both perpetration and victimization of violence. However, other features related to increased violent victimization are contextual factors that are all characteristic of disadvantaged neighbourhoods and social disorganization.

It is clear that other influences besides individual psychopathology are involved in the violence of the mentally disordered. These context-specific factors in violence are also supported in recent research, showing that subjective feelings of threat combined with severe notable psychiatric symptoms result in significantly more aggression and violence in mentally ill subjects (Hodgins et al., 2003). However this being noted, one must not overestimate the actual prevalence of violence resulting from mental illness. Stuart and Arboleda-Florez (2001) have warned against the criminalization of offenders with psychotic disorders, and suggest that public fear and community care policies overestimate the actual risk posed by such individuals. This public reaction relates back to the issue of stigmatization discussed earlier while providing yet another external factor to the possible relation of victimization to mental disorder. Frustration and fear resulting

from interactions with the mentally ill may lead to conflicted social relationships and, therefore, greater opportunity for violence.

Further to Hiday's work on victimization and social networks, Silver's (2000) research suggests that one needs to understand community-level factors (such as risk factors for violence) in order to accurately estimate the effects of individual-level factors for violent behaviour. His study found significant support for the idea that patients who are discharged into socially disorganized neighbourhoods were more inclined to engage in violence than those discharged into less disadvantaged neighbourhoods (Silver, 2000). Kubrin and Weitzer's (2003) study on the interaction of formal and informal social control in neighbourhoods is one way to address Silver's recommendation, while another is to examine the role of adversity and stress in intense situations so as to incorporate community-level factors with the mentally disordered offender.

Stressful interpersonal relationships are often commonplace for mentally disordered people, in particular those experiencing high rates of violence and victimization. These patients are typically more involved in conflict in their social relationships and are victimized in these relationships at a more significant rate (Silver, 2002). The difficulty with social relationships has been characterized in the following way:

...Disorders of thought and mood not only distort one's subjective appraisal of experience and threat, but impair the ability to relate meaningfully to others. Thus, social contact may be a mixed blessing for [severely mentally ill] individuals. For some, it signals a positive quality of life, but for other – particularly those with extreme psychiatric impairment – frequent contact may add to conflict, stress, and increased potential and opportunity for physical violence. (Swanson et al., 1998, p. S86)

The above authors found that, for individuals with severe psychiatric impairment, frequent social contact increases violence risk, while the opposite relation is true for those with less functional impairment. Therefore, a strong relationship exists between social interaction and its effect on the violence experienced or perpetrated by mentally disordered individuals. In testing the hypothesis that psychopathology is associated with reduced social contact, Swanson et al. (1997) found some support for the idea that this social isolation is not only more prevalent for individuals with major mental disorder, but also reduces the number of targets of violence available to the patient. This relationship was specifically examined with respect to violent targets, but could also theoretically be applied to a diminished interaction with any social contacts. Estroff et al. (1998) showed that targets of violence are typically drawn from these small groups of social contacts, and that immediate family members are at highest risk for being a target. These studies serve to demonstrate the dual effect of social networks on violence with it being either beneficial or detrimental to the violent behaviour of individuals, depending on their level of psychiatric impairment.

Similarly, studies on violent victimization of the mentally ill have shown significant relationships with future violence, violent crime, and substance use (Swanson et al., 2002; Hiday et al., 2001). The suitability of targets of violence will also be influenced by comorbid mental health issues such as substance abuse (Swanson et al., 2002; Silver & Teasdale, 2005). Individuals suffering from a mental disorder in combination with substance abuse may exhibit different target-seeking behaviour by searching for specific targets such as drugs and alcohol that serve to reduce psychotic symptoms. Fundamentally, these studies explore how the mentally disordered offender

may have specialized needs and motivations that drive them toward criminal and violent behaviour—and that these needs are not adequately addressed in their social networks. Substance abuse has been suggested as the most important mechanism linking violence to mental disorder and operates exclusive of social relationships (Swartz et al., 1998). Substance abuse not only interferes with cognitive function and behaviour thresholds, but also situates individuals in an environment that exposes them to increased social disorganization. Communities that tolerate drug and alcohol use also provide opportunities for violence, homelessness, and conflicted social interactions. Involvement in mental health treatment programs and medication compliance are shown to arbitrate these negative influences on violence, whether by providing supportive interpersonal relations or by reducing access to harmful drugs and alcohol (Swanson et al., 1997). It is, therefore, imperative to assess the varied impact of substance abuse on severe mental illness both as an issue in treatment and in the context of community integration.

4.4 Is Substance Abuse a Mental Health Issue?

Substance use literature has not made a clear distinction between the varied effects of substances on the brain. Substance use can be recreational or infrequent, and in these cases is likely to have different consequences for health than the more pathological substance abuse³. Similarly, the abuse of drugs and alcohol does not necessarily bring about a dependence or addiction to the substance, although the risk for dependence is greatly increased. Consequently it is remarkable that the same legal threshold that applies to mental disorder provisions in criminal law likewise applies to severe substance use.

³ Substance abuse is defined here as substance use behaviour that has come to have significant impairment on a person's functioning. Substance dependence includes continued substance abuse behaviour despite the onset of problems, while including an increasing tolerance to the substance and withdrawal symptoms (DSM-IV-TR).

This threshold of producing a mental state akin to a ‘disease of the mind’ is dubious since there is little agreement within drug and alcohol literature on the degree of dependence that is necessary to define drug use as a disease. As stated in a report from the World Health Organization (WHO) (2004):

Substance dependence has not previously been recognized as a disorder of the brain, in the same way that psychiatric and mental illnesses were previously not viewed as such. However, with recent advances in neuroscience, it is clear that substance dependence is as much a disorder of the brain as any other neurological or psychiatric illness. (p.14)

This statement demonstrates that regardless of the voluminous scientific theories that explain the relationship between substances and behaviour, it is clear the WHO supports the idea that drugs and alcohol do have the ability to affect the brain in similar ways as mental illness. Drugs and alcohol both pose a threat to the normal performance of the brain, and can have negative results on individual behaviour and function.

4.4.1 Comorbidity of Mental Disorders and Substance Abuse

While the occurrence of a mental disorder has a compelling effect on the brain and behaviour, a co-occurring substance abuse disorder can only add to the negative impact. The intersection of the issues of mental disorder and consumption of drugs or alcohol is manifested in a dual diagnosis for abuse or dependence on a substance. When an individual has a mental illness as well as problematic substance use, these issues become comorbid⁴, or occur at the same time, and thus bring about a new challenge for treatment strategies. International opinion has suggested that comorbidity indicates a common biological basis for each disorder, or that some elements of each disorder

⁴ Comorbidity describes the diagnostic co-occurrence of two or more disorders in the same individual. These disorders influence the course of one another and should be considered as inter-related when examining treatment options.

interact to perpetuate the other's progression (WHO, 2004). Since both disorders are considered mental health issues, it seems reasonable to hypothesize that they each stem from similar organic roots which allow them to occur at the same time. However, substance use may produce outcomes that are conducive to mental illness by alleviating symptoms of the illness itself or by masking unpleasant side effects of psychotropic medication (WHO, 2004). Consumption of drugs and alcohol can produce mood-altering states or at least can alter the operation of the brain in ways that may relieve some negative effects of mental disorder. In this way, all types of legal and illegal drugs may offer relief of symptoms of mental disorder. For example, mentally disordered patients with substance dependence are more vulnerable to smoking, an activity that occurs at remarkably high rates in those suffering from psychiatric illness (Vanable et al., 2003). Therefore, the abuse of an illegal substance increases the risk of using legal but damaging nicotine. What is concerning are the uncontrolled effects of drug and alcohol use experienced by mentally disordered patients and the degree to which substance abuse poses an added health threat to mentally disordered users.

Several studies have looked at the prevalence of comorbid substance abuse and mental disorder and have consistently found higher rates of pathological substance use among individuals with serious mental illness. A study done in the United Kingdom has shown that as many as 20% of patients suffering from severe mental illness also are problematic users of drugs and alcohol (Virgo et al., 2001). Furthermore, the authors reported that 33% of all patients with serious mental disorders had abused substances at some point in their life, where patients with a dual diagnosis had the most acute substance problems. This study emphasizes that, while an official diagnosis of chemical

dependence/abuse highlights patients with the most extensive substance use problems, there is still a large portion of the mentally disordered community who may not be receiving the attention that is needed for their lesser substance use problems. This assertion finds support in RachBeisel et al.'s (1999) review of research on mental illness and substance use, where the prevalence of substance use disorders was much lower in the general population than in patient samples with mental illness. One Canadian study has even shown an 82% comorbidity rate for substance abuse and psychotic illness in a prison population (Brink et al., 2001). The consumers of substance treatment programs in the general population are therefore quite distinct from the dually diagnosed patient. This reaffirms the need for substance abuse awareness in the realm mental health, and speaks to the difficulties in simultaneously providing treatment options that target mental health consumers differently from the general population.

There is also strong support indicating that substance use produces adverse effects on the course of mental illness through interference with symptoms, lower social functioning, medication compliance, and more frequent hospitalization (RachBeisel et al., 1999). While these characteristics are already present when examining the mentally disordered, they are further intensified by substance abuse or dependency. Access to mental health treatment is often limited; introducing a substance abuse problem only creates ambiguity in relation to the course of treatment that will most impact a patient's social functioning. Nevertheless, there is consensus that substance abuse occurs more frequently in patient populations, but the explanation for this trend is still suspect. Many complicating factors arise in the relationship between mental illness and substance use, including the role of social relationships, gender, and experiences with violence. These

factors are each experienced in a particular environment, whether that is an outpatient clinic, a residential setting, or in the community. In order to better understand the influence of dual diagnosis on these measures, an examination of each environment will be undertaken within the auspices of social disorganization.

4.4.2 Social Relationships and Environmental Characteristics

In applying social disorganization principles to our understanding of mental illness and substance abuse, one must focus on the environment of an individual as a trigger for abusing behaviour. This environment includes the neighbourhood in which individuals live, the social connections they have with other people, their associations with family, and the quality of housing and employment available to them. These characteristics of a person's surroundings have been shown to affect not only the progression of mental illness, but also of a substance abuse disorder. When found in combination, mental illness and substance use are even more affected by a surrounding environment that is characterized by disorganization, isolation, and social strife than is the case when each disorder is experienced alone. Support for this idea comes from Mowbray et al.'s (1997) study on dually-diagnosed patients. This study explored the results of clinical, social, and community functioning variables with a population of severely mentally disordered and substance-abusing patients in a hospital sample. It was found that very few participants identified themselves as being involved in any strong social relationships with spouses, family, friends, or children (Mowbray et al., 1997). This is a troubling finding since this study represents a group of individuals who are at most need for social support and peer associations.

Without the ability to relate meaningfully to other people, mental health can deteriorate and stress levels can increase. Kawachi and Berkman (2001) explored the issue of social bonding and mental health and found support for the hypothesis that social isolation partially underlies the deterioration of mental health. The authors offer two models for understanding the impact of social ties on mental health: the main effect model suggests that integration into a social network can produce positive changes in psychopathology, while the stress-buffering model explains that perceived or actual support can reduce negative emotional reactions to stressful events (Kawachi & Berkman, 2001). These models of social bonding are congruent with the principles of social disorganization in that they both suggest factors outside the individual can have positive and negative effects on their mental health. It is important to recognize the impact of social connections on mental disorder, and likewise the impact it has on substance abuse. Isolation from support networks such as friends and family is almost certainly indicative of segregation from other community members, including treatment groups in the community. That being said, one must recognize that the effects of social ties and community support are not going to affect all people in the same way. There is a contextual element to human interaction and while it may be advantageous to have social interactions in some circumstances, there are certain occasions upon which these social interactions can actually lead to more detrimental outcomes for mental disorder and substance abuse.

Individuals with severe mental illness are already encountering stressful events in their lives such that substance use may represent an avenue of temporary relief from life's troubles. In qualitative interviews, patients with comorbid substance use indicated that

poor housing, unemployment, legal problems, and poor family relationships were all issues that triggered substance use (Bradizza & Stasiewicz, 2003). These life events are stressful and negative, and fit well within the stress-buffering model of social ties discussed above (Kawachi & Berkman, 2001). Communities with high levels of social disorganization are more likely to have problems with housing, unemployment, mental disorder, and substance abuse; therefore, when stressful issues arise and are not mediated by social support, a trigger for substance abuse is more pronounced. Furthermore, access to drugs and/or alcohol, and being surrounded by solicitation to buy drugs are highly associated with substance abuse for the mentally ill (Bradizza & Stasiewicz, 2003). Having easier access to illegal drugs by living in neighbourhoods with a marked incidence of drug trade and drug use seems to encourage drug and alcohol abuse in individuals with a mental disorder. One study showed that 77% of dual-diagnosis subjects found it easy to buy drugs in their neighbourhoods and only a minority felt safe in their areas (Mowbray et al., 1997). A low level of social organization—as demonstrated through feelings of safety and access to drugs—is, therefore, a common characteristic of the lives of mentally ill substance abusers. This drug trade need not only be conducted by street dealers and neighbourhood traffickers, but can also be reflective of peer influences on drug and alcohol use. When friends or acquaintances offer substances to the dually diagnosed, these offers are more persuasive and are considered a strong trigger to substance use. As Bradizza and Stasiewicz (2003) describe:

Many individuals in different [focus] groups talked about the difficulties in maintaining abstinence in an environment in which friends or family abused alcohol and drugs. They described living in neighborhoods in which they essentially felt surrounded by drugs and drug users. Participants stated that meeting up with people they used to use drugs with was a strong trigger for relapse. (p. 163)

These friends and family offer attractive opportunities to avoid isolation while additionally providing an escape from the negative psychological effects of mental disorder through substance use. It appears that social contacts are significant in the relationship between mental illness and substance use when they are situated in an area of weak social control where drugs are more available.

Another environmental trigger for substance use is the availability of funds to purchase drugs or alcohol. Since a frequent feature of mentally ill substance abusers is unemployment and use of government assistance, it follows that the sources of income will most commonly come from borrowed sources or social assistance programs (Mowbray et al., 2003). This lifestyle means that income arrives sporadically and infrequently, as social assistance is often paid once a month. For this group of people, research indicates that monthly money management (as opposed to bi-weekly or weekly income) can be overwhelming and ineffective. While money management has been found to be a significant problem for individuals with only a psychiatric problem, it has been noted as being even more of an issue for dually-diagnosed individuals (Rosen et al., 2002). Substance use seems to intensify the serious difficulties associated with income management even though it is already a prominent problem for the mentally disordered. This infrequent flow of income, combined with an environment conducive to drug and alcohol abuse, often leads to a trigger for alcohol and drug abuse (Bradizza & Stasiewicz, 2003). Therefore, the impact of living in areas of increased social strife with elevated levels of unemployment, drug availability, and pressure to use substances can inevitably lead to a difficult environment for substance-using patients with severe mental disorder.

4.4.3 Influence of Personality Disorders

Cleckley outlined the traditional view of psychopathy in 1941 as a series of personality features such as arrogance, manipulation, lack of empathy, impulsivity, and proneness to violate social norms (Hart & Hare, 1997 as cited in Arrigo & Shipley, 2001). By contrast, the formalized psychiatric disorder was adopted from early descriptions of a psychopathic or sociopathic personality and restructured into a defined set of diagnostic criteria under the name of Antisocial Personality Disorder (ASPD). Levenson (1992) has challenged the traditional conceptual framework of psychopathy, suggesting that, instead of a biological or social cause for psychopathy, we should instead be viewing psychopathy as a mode of operating in the world. Indeed, an individual is not a psychopath, but can act psychopathically if he or she learns to experience reduced anxiety in response to violating social norms. Moreover, there is conflict within the profession of psychiatry as to whether the personality disorders, including ASPD, should even be defined as mental illnesses (Kendell, 2002). Regardless of whether personality disorders should be defined as psychiatric disorders or should simply be considered personality types, it is important to consider the influence they may have on substance abuse in mentally disordered individuals.

4.4.3.1 Interaction of Personality and Substance Abuse

Often individuals are considered as having one mental health problem exclusive of any others, when in fact the co-occurrence of mental disorder, substance abuse, and crime has received considerable support in the scientific literature (Abram, 1989; Abram & Teplin, 1991; Hodgins, 1995; Tengström et al., 2000)). Severe psychiatric disorders, alcohol and drug abuse, and antisocial personality have been found to be co-occurring

and persistent over a lifespan with samples of male prison inmates (Abram & Teplin, 1991). They showed that inmates with severe mental illness are also highly likely to abuse alcohol (80-90%), abuse drugs (45-60%), and exhibit antisocial personality (65-85%). This reciprocal relationship between the personality, mental disorder, and substance abuse is obviously strong and is a critical feature of potential treatment difficulties.

Abram (1989) explored the relationship between these factors and found that each variable of alcohol abuse, drug abuse, and ASPD increased an individual's possibility of arrest, but was compounded when these variables occurred together. This finding suggests that ASPD has a high tendency to occur with other diagnoses. Crocker et al. (2005) also found that ASPD and psychopathy are predictive of aggressive and violent behaviour, especially when found in combination with substance abuse—an important factor when considering risk in mentally disordered offenders. Tengström et al.'s (2004) results indicate that among offenders with schizophrenia, as among non-mentally ill offenders, high ratings on the Psychopathy Checklist Revised (PCL-R) are associated with more severe histories of offending and violence. Offenders with schizophrenia who had high scores on the PCL-R, and those with and without substance use disorders, had been convicted, on average, for similar numbers of offenses and for similar numbers of violent offenses. Therefore, when devising a treatment or release plan, research shows that personality traits of psychopathy should be considered because of their association with less improvement during treatment and higher rates of recidivism after treatment (Skeem et al., 2002).

4.4.3.2 Prevalence of Dual Diagnosis and Severe Personality Disorder

Seto et al. (2004) compared forensic and civil patient populations on a variety of psychiatric, social, and criminogenic scales. In finding that forensic patients exhibited less criminal, clinical, and social problems than their civil counterparts, this study brings to question whether these are truly features that define the forensic population. It is of particular interest that while their forensic sample seemed to have more acute and persistent psychiatric histories than the civil sample, the civil patients showed a significantly higher rate of antisocial traits and aggression (Seto et al., 2004). By contrast, Rotter et al. (2002) found that ASPD occurred roughly three times more often in forensic patients than in their civil counterparts.

A British study found that there is a relatively strong correlation between Axis I and Axis II disorders (Blackburn et al., 2003). There are high rates of personality disorder among mentally ill offenders—described in previous research as anywhere from 20% to 65% of mentally disordered patients having also been diagnosed with a personality disorder. These researchers found ASPD and psychopathy to be co-occurring significantly with Post Traumatic Stress Disorder and drug abuse.

It has been suggested that psychopathy and ASPD are potentially untreatable as mental disorders and interfere with the treatment amenability of an individual who suffers from a concurrent mental illness (Shipley & Arrigo, 2001). Since treatment may not be an option for these impairments or personality types, focus should be placed on aspects of the treatment plan for Axis I disorders that could be influenced by the presence of a personality disorder. This includes the potential for treatment compliance, drug and

alcohol abuse, and involvement in crime, all which may negatively impact a person's reintegration into the community.

4.5 Gender Differences

It is important to recognize that the social context of mental illness will be experienced differently by men and women under certain circumstances. While there are many shared perceptions and occurrences that form the lives of the mentally disordered, they will necessarily experience gender variations just as the general population does. Most notably, their interactions with violence and the features of this aggression are markedly different. Current research has failed to find a significant variation in rates of violence between men and women, as both groups show an approximate rate of 50% (Robbins et al., 2003; Hiday et al., 1998). However, the types of violent acts, targets, and location of the aggressive event seem to be influenced by gender to a significant degree. Robbins et al. (2003) found that, in a sample of mentally disordered adults, women are more likely than men to endure and inflict violence that produces less harm (such as a push, grab, or slap) whereas men were more prone to violence and violent action that resulted in greater physical injury (such as a bite, kick, or punch). These variations in types of violence suggest that men are at greater risk of producing grievous injury to their victims and are likewise going to sustain more damage when they are victimized. The ability to inflict more damage to another individual may also account for the increased

likelihood for men rather than women to become involved with law enforcement when suffering from mental disorder⁵.

As is the case with levels of harm, differences in locations and targets of violence have been found between the genders. Studies have consistently shown that women are significantly more likely to experience violence in the home and men have higher rates of street violence or violence in a public place (Robbins et al., 2003; Hiday et al., 1998). Consequently, the selection of targets or the individuals who are involved in the violent encounter are unavoidably going to occupy different roles in the mentally disordered individual's social network. Thus it follows that women tend to target family members or their partners at a more significant rate, and men will be involved with friends or strangers in their aggressive acts (Robbins et al., 2003; Hiday et al., 1998). These categories of targets intuitively fall into the environmental context of the home and the street respectively. The results of these studies indicate a significant variation in men and women's experiences with violence, and suggest that interventions need to recognize the distinct relationship of gender to violence in order to be effective in violence prevention. Building on this idea, research has begun to examine the gender differences in reactions to stressful events, and to apply a more sociological model in combination with the medical model when exploring issues of mental illness (Aneshensel et al., 1991). However at this time, gender issues and their impact on the offending behaviour, target selection, and differences in guardianship are under-explored in most social ecology perspectives, and are especially overlooked in the literature pertaining to mental disorder and environmental influences.

⁵ In a study done by Clark, R.E., Ricketts, S.K., & McHugo, G.J. (1999) on mentally disordered patients and their involvement in the justice system, elevated rates of legal involvement were found for both men and women, but men had longer records and more frequent involvement.

In addition to the above gender differences, health and welfare needs outside of violent victimization need to be addressed distinctly for the sexes. In their qualitative exploration of health needs of mentally disordered women living in rural areas, Lyon and Parker (2003) enumerated the themes of limited access to care and the need for an integration of mental and physical healthcare services. These issues were of specific concern for women, but are also of obvious interest for men who are suffering from mental illness and not experiencing continuity in their healthcare programs. One theme that seems distinct for women is the difficulty in adjusting to the profound loss and depression resulting from having restricted visitation with their children or having children removed from their custody (Lyon & Parker, 2003). Since children are often under the care of the mother and this nurturing role is a part of defining maternal identity, many mentally disordered women are deprived of the opportunity to raise their children owing to the invasive nature of mental disorder and its impact on daily functioning. However, this positive opportunity for mentally disordered women to raise their own children must be weighed against the possible risks to children who are under the care of parents who are suffering from a mental illness.

The reality of impaired functioning is most prominent when relating mental disorder to housing issues and socially disorganized neighbourhoods. Mental health problems are among the leading causes of homelessness, regardless of gender effects (Tessler et al., 2001). However, it is interesting to note that men and women experience the impact of their mental disorder as affecting different areas of their functioning, and therefore report different reasons for homelessness. Men report significantly more psychological reasons for their homelessness, including mental health problems, drug and

alcohol abuse issues, and other negative influences on their capacity for independent living (Tessler et al., 2001). This finding essentially shows that deficits in men's ability to support themselves can result in greater rates of homelessness. Whereas women report more interpersonal reasons for living on the street, most notably eviction, conflict with others, and their social network no longer being willing or able to help (Tessler et al., 2001). These reasons support a more dependent relationship of women to others, and indicate that a collapse in their social supports can be disastrous for mentally disordered women and their ability to self-support. Each of the differences specified above suggest the mediating role that gender can play in the interrelationship between mental illness and environmental context. The features of social disorganization are not experienced uniformly; therefore, strategies for dealing with the resulting social problems must be cognizant of these differences.

4.6 Policy Issues and Geographical Variations

While social disorganization has been shown to interact distinctively with mental disorder, it is the influence of substance abuse, conflicted relationships, violence, and gender differences that can make an already difficult social environment worse (Swanson et al., 1999). These features exacerbate the impact of mental disorder on the lives of patients by exposing them to surroundings that are characterized by social conflict and disadvantage. Exposure to dangerous environments is demonstrably related to problems with mental disorder and in order to address this trend, an integration of social disorganization issues into the decision-making process of release boards and tribunals must be made. Edens and Otto (2001) have described the procedures that review boards should consider when making release decisions for psychiatric patients. It is expected that

review boards concentrate on the detection of individual risk factors for recidivism; however, this focus does not explore the full spectrum of risk opportunities that a released person will face in the community. Edens and Otto (2001) identify the need for an identification of risk factors in the previous, current, or proposed living environments of patients and stress the importance of looking beyond individual-level pathologies to contextual factors for violence and recidivism. They state:

...It seems clear that focusing only on the characteristics of the offender to the exclusion of the characteristics of the system in which he or she is functioning will ignore a wealth of information that is directly relevant to his or her ultimate probability of success on conditional release. (p.347)

The inclusion of environmental features in risk management can only aid in the successful integration of patients into the community by properly acknowledging that outside influences can have a substantial impact on the behaviour of the mentally disordered. New directions in risk management, as opposed to risk assessment, are considered further in the discussion chapter of this study.

Further support for the integration of community factors into release plans extends to the relevant clinical judgments for effective community management of release patients. Contextual variables such as psychological deterioration, alcohol, troubled social relationships, and drugs have been shown to underlie the clinical decisions of treatment teams when determining the risk for violence posed by released individuals (Mulvey & Lidz, 1998). These clinical decisions impact upon community safety levels; therefore, it is paramount to consider all applicable influences on potential violence, including environmental effects. That being said, it is necessary to address the complicating factors of stigma and public fear when making treatment release decisions.

In her examination of mental health policy in the United Kingdom, Wolff (2002) suggests that treating mental illness is not necessarily more difficult than treating other physical ailments, but it is the fact that mental disorder is perceived as both an illness and a risk factor for violence that sets it apart. Therefore, areas with high numbers of released patients will be perceived as having more potential for violence and thus be deemed less desirable to reside in. This helps to explain why the few areas that have mental health hospitals and clinics often have more mentally ill people living in their proximity and tend to attract even more vulnerable groups from around the regions (Wolff, 2002). As vulnerable groups begin to congregate in an area and perception of the risk of violence increases, the degree of social disorganization increases.

Heilbrun and Griffin (1998) expand the scope of environmental factors, suggesting that treatment strategies need to be made in a process of collaboration between the criminal justice and mental health systems. Since it is widely acknowledged that the mentally disordered may be displaced into the criminal justice system once released from hospital, it is not unreasonable to attempt to integrate the treatment strategies of these two realms (Chaiklin, 2001; Swanson et al., 2001). Both the prison and hospital systems are critical for the provision of mental health services; thus, they encounter the same individuals who are experiencing poverty and homelessness in conjunction with their mental disorder. For example, the United States has recently employed involuntary outpatient commitment as a means of integrating released patients into the community while addressing the perceived risk to the public (Swanson et al., 2001). Canada has similar provisions available for releasing involuntary patients from custodial care; however, each province's mental health legislation dictates a slightly

different procedure for providing outpatient intensive treatment (Gray & O'Reilly, 2001; Davis, 2002). As such, Ontario's community treatment orders (CTO) are applied in slightly different circumstances than British Columbia's conditional leave status: Ontario's CTO's can be applied to a patient who is not currently receiving involuntary treatment in hospital yet requires more intensive community supervision than is generally provided, whereas British Columbia's on-leave status must be applied to an individual who is both involuntary and receiving in-patient treatment (Gray & O'Reilly, 2001). Both Canadian approaches demonstrate a concern for the concept of intensive supervision of the seriously mentally disordered in the community, and convey an interest in providing similar safeguards to mentally disordered offenders and NCR accused persons discharged from forensic care. Nevertheless, the levels of affluence and social disorganization in different communities will no doubt temper acceptance of outpatient commitment, with individuals being released into areas with higher social conflict in order to be geographically near to mental health services. Strategies that directly confront the disruptive community structures of socially disorganized neighbourhoods can only have a positive effect on the levels of stress in the lives of released hospital patients. Alternately, community services can be moved from areas of high social conflict and disorganization into regions that do not have the same negative influences on mental health. However, problems have been noted with respect to community acceptance of mental health services in more affluent neighbourhoods and the limited effect that proximity to services has on psychiatric disorders (Smith, 1976; Dear et al., 1980). More recently, and most applicable to the NCR accused persons involved in this study, there was widespread opposition by community residents against a dual-diagnosis residential facility being

located in a South-East neighbourhood in Vancouver, British Columbia (Whitlock, 2004). These studies and examples serve to reinforce the preeminent issue of negative public reaction and social stigma that characterizes new mental health policy development.

Beyond the impact of release practices, geographical representations of mental illness can be instructive when determining locations of release and areas of mental health service concentration. A consideration of the geography of mental illness in the creation of policy can lend significant insight into the distribution and allocation of resources. Holley (1998) suggests designing geographic models of mental illness and mental health services that will enlighten program planning, mental health policy development and allocation of funding. These geographical representations can help identify areas of increased mental health needs as well as regions of social disorganization that may be negatively affecting the progression of patients' recovery and community functioning. There is a shift in interest directed towards the geography of mental health as the influence of external community factors are recognized in the progression of mental disorder (Holley, 1998). However, while it is important to decipher which neighbourhoods of a particular area are receiving higher numbers of mentally ill persons and are providing more mental health services, it is not sufficient to limit the applicability of geography in this way. The examination of these demographic features, while informative, does not clarify the specific socioeconomic, relational, and cultural climates of these communities. In response, Wolch and Philo (2000) suggest a new approach in mental health geography that integrates socio-cultural research with geography and politics/economics in order to provide strategic direction for policy

development. Consequently, it is not the specific location in an urban landscape of mental disorder that is important for policy, but rather the characteristics of social disorganization in those areas.

Additionally, there is a need to supplement such geographical representations of social disorganization with more qualitative research that examines subjective experiences in these communities (Wolch & Philo, 2000). Interviews and focus groups allow for the articulation of the importance of contextual factors in the overall function of the mentally ill living in the community. These serve to complement the more geographically oriented representations of community social disorganization, while additionally providing a deeper insight into the experiences of the mentally ill in the community. For example, qualitative interviews exploring the role of social supports in the lives of mentally disordered offenders would be most beneficial to the comprehension of barriers to this group's community reintegration. Interviews on this topic will reach a deeper understanding of not only the presence or absence of social support—as is found in quantitative research such as Silver and Teasdale's (2005)—but also of an individual's subjective reliance on such support in their daily lives. This is an often overlooked area in the study of mental health, where the perceived need for social support has been applied in research with only moderate consideration to the degree to which it is welcomed. Similarly, focus groups with current forensic mental health consumers could greatly enhance mental health geography research by assessing what the felt needs are of forensic patients who are on leave or on conditional discharge in the community. Focus groups could explore subjective feelings of safety in their communities, feelings of inclusion, access to transportation, access to mental health services, or financial

challenges upon leaving the institutional setting. Once the geographical distributions of forensic clients are determined, it is enriching to understand these patients' perceptions of their own neighbourhoods and social welfare needs through qualitative studies.

Therefore, the integration of both qualitative and quantitative methods for exploring social disorganization and mental illness can provide the most complete understanding of environmental factors that impact the successful reintegration of the mentally ill into their communities.

4.7 Conclusions

As viewed through the lens of the current literature on mental illness, the exclusive focus on individual-level psychopathologies has broadened to include a discussion of social and environmental variables that affect the behaviour of the mentally disordered. This discussion of social disorganization is most valuable when it includes community variables such as community guardianship and other neighbourhood-level characteristics. These informal social controls are found to be weak in areas of social disorganization and can impact negatively on the global functioning of a mentally disordered individual. Further to community guardianship, the influence of social networks and positive social contact is shown to contribute to an individual's overall stress and likelihood of being involved in social conflict. This social conflict is most notable for women, and affects the way in which they experience violence.

Violent actions and violent victimization are overwhelmingly discussed in the literature as being related to mental illness. Victimization occurs in part as a consequence of the opportunities presented in disadvantaged areas, and in part as a consequence of the individual's level of involvement in a social network. Neighbourhood characteristics such

as access to illegal substances, poverty, and homelessness are influential in the victimization rates of this population and likewise related to their perpetration of violence against others. Choices of targets for violence are clearly related to levels of social contact with others, as demonstrated by the prevalence of violence against family members. It is interesting to note that targets of violence differed significantly between men and women and that locations of such violence are also dissimilar. As women are more inclined to experience violence in the home and with a family member, it is clear that while domestic social relationships may be more subjectively important to female patients, they may also be characterized by conflict. Conversely, the reality of men experiencing their violence on the streets (and more significantly with strangers or acquaintances) suggests a potential reason for why men have more contact with the justice system in combination with the mental health system. Each of these factors in social disorganization has produced important results on the function of the mentally ill in the community.

It is encouraging to see a gradual acceptance of social ecology and mental health geography in the policies governing the release of mentally disordered persons. By following the suggestion of Edens and Otto (2001) and integrating community factors into release decision-making, we can hopefully address some of the features of socially disorganized neighbourhoods and make successful community integration more feasible. It is therefore crucial to acknowledge the role that external environmental factors have on psychopathology and the successful functioning of patients in the community.

CHAPTER 5: METHODOLOGY

5.1 Background

While the fields of environmental criminology and mental health policy are developing autonomous theory and research relating to crime, their independent routes have not yet intersected at a nexus that studies not-criminally-responsible accused persons in their physical environment. The purpose of this research is to add to the existing literature in the field of mental disorder and crime, while incorporating a new environmental perspective: the relationship between the geographic and socioeconomic characteristics of a community and the crime patterns of the not-criminally-responsible (NCR) accused. Through an examination of the release patterns and residences of the NCR accused, the present thesis investigates the extent to which the geographical regions of British Columbia's lower mainland are a significant influence on conditionally discharged patients. Additionally, this study examines the extent to which environmental factors are considered in the release decisions of the British Columbia Review Board, in order to assess the inclusion of contextual variables in their decision-making. This research issue is analyzed through the use of quantitative descriptive statistics and graphical representations of the distribution of released patients.

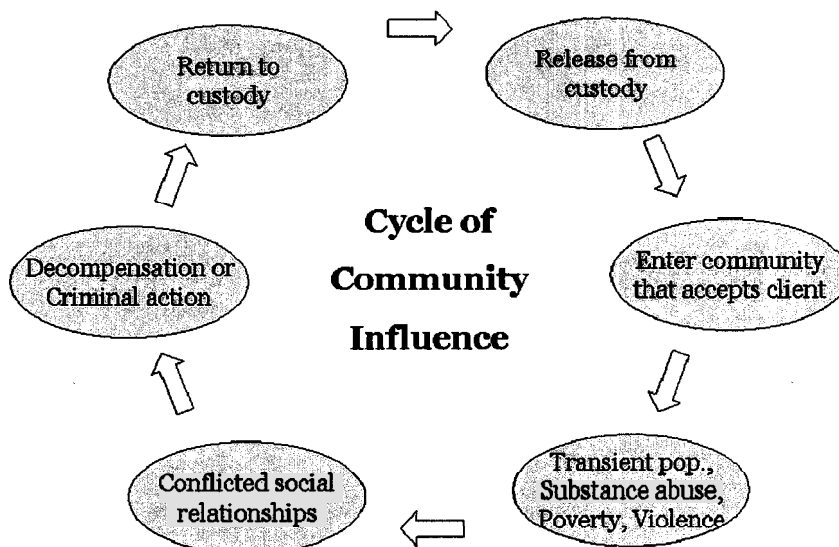
This exploratory study is innovative insofar as it combines the interests of urban planning with psychopathology and criminal justice. While historically it has been difficult to provide effective crime control programs for the not-criminally-responsible accused when they are released from forensic care, the development of a greater

understanding of the nature of environmental interactions will prove beneficial in advancing new crime-management strategies. The results of this study will draw a preliminary picture of socio-geographical features that affect recidivism in this population and can provide direction for future research and policy development in the realm of community release programs from forensic custody.

By drawing from the theoretical background, legal structure, and scientific literature outlined in previous chapters, this empirical research project follows a model of community influence that is specifically designed to explore the issues facing released forensic patients. As suggested by social ecological theorists, social disorganization influences a community's collective ability to exert informal social control over their residents. The community provides guardianship by setting rules of conduct and intervening when these rules are broken. However, forensic clients break these informal rules of conduct by the nature of their psychiatric illness and their criminal history. It follows that neighbourhoods with higher levels of social organization have the power to reject these clients from their communities because they are able to collectively enforce their codes of conduct. Therefore, the resulting experience for forensic patients should be that they are likely to live in an area that is more accepting of their illness and behaviour. Such an area will have more flexible rules of conduct not only in the realm of their acceptance of overt psychiatric illness, but also in other typically troubling characteristics of residents such as crime, substance use, transience, and conflict. These neighbourhood-level influences are divided into three main categories: social-support networks, community context, and environmental/location factors. As far as social-support networks are concerned, the possibility of social isolation exists if a released forensic

client's relationships are not strong with friends, family, or their treatment team. These relationships can both mediate a stressful situation and exacerbate the social pressures experienced in the community. Community-context influences can include violence in the neighbourhood, access to alcohol and street drugs to self-medicate, or participation in a social network of substance users in order to have social interactions with other community residents. In more compelling accounts of community influence, a mentally disordered individual living in the context of a high crime neighbourhood is potentially exposed to low levels of informal social control and can lead to the criminal justice system being used to access mental health services (Silver, 2000a). Finally, the environmental factors encountered by patients who are released into different communities must be considered. If forensic clients are released into neighbourhoods with socially disorganized features, and treatment services are placed in neighbourhoods with socially disorganized features, the unintended effect is the exposure of clients to community characteristics that may make them vulnerable to criminal activity and/or psychiatric decompensation. This influence is noted in Figure 1:

Figure 1: Cycle of Community Influence



Overall, this theorized cycle of neighbourhood influence leads to some important implications for the forensic system. Since mental health systems are moving further toward a community-treatment model, it is necessary to determine the barriers that may be involved in various neighbourhood settings. This includes reviewing the placement of treatment facilities, examining the decisions of Review Boards for their consideration of community variables, and recognizing the need for inclusion of environmental factors in risk management. By incorporating geographic models into mental health practice, we can begin to understand where this population lives and what types of barriers they may face in successful community reintegration.

5.2 Issues of Study

In combining the areas of mental disorder and social disorganization, this study addresses various research questions regarding the release of NCR accused from custodial care. These questions include:

1. What are the characteristics of those found NCRMD who were released on conditional discharge during the five-year period, 1998-2003?
2. Are geography and living situation factors that are mentioned in the Review Board's decision-making and release plans? To what degree are these factors influential on the decisions of the Board?
3. Are conditionally discharged patients more likely to be sent to certain areas of the lower mainland upon their release? What are the characteristics of these areas?

4. What regions of the lower mainland show an increased likelihood of a resident patient returning to hospital, having their discharge revoked, or conditions altered?
5. Do these issues impact male and female NCR accused persons differently?

Based on the current literature in the area of mental illness, social and contextual factors, particularly in areas of high social disorganization, have been demonstrated to be influential on a patient's ability to function in the community. Therefore, the goal of this study is to establish the applicability of environmental factors to the mentally disordered criminal population.

5.3 Research Sample

The research questions were addressed through the analysis of documentation held in patient files at the Forensic Psychiatric Hospital in Port Coquitlam, British Columbia, Canada. Access to these health records was approved in July 2004 by the Forensic Psychiatric Services Commission, under the Provincial Health Services Authority, with the understanding that this researcher could make use of all documentation held within including psychiatric evaluations, nursing notes, social work case histories, criminal histories, and British Columbia Review Board decisions. Collection of this data took place from August 2004 to March 2005 in order to accommodate the length of time it takes for updated information (such as address changes and returns to hospital to reach recent patients' files). It was this researcher's intention to access supplemental qualitative data through the BC Community Legal Assistance Society regarding patients who were absolutely discharged from forensic care;

however, owing to unforeseen difficulties, this portion of the project was not carried out. This issue will be addressed at greater length in the discussion of directions for future research.

This study is an attempt to examine the geographic patterns of NCR accused persons who are released on conditional discharge. Since this level of psychiatric impairment is a relatively uncommon affliction in any population, an unrepresentative sample was selected from a population large enough to reflect the characteristic being tested. A population drawn from a forensic psychiatric hospital provides an ideal base from which to draw a smaller sample. There will necessarily be a higher rate of mental illness in this population than in the general public and the severity of the mental disorder will be of a calibre that interferes with normal functioning.

The sample was drawn from patient files at the Forensic Psychiatric Hospital and included only those individuals who were found NCRMD by the British Columbia courts. It is important to note that not all of the patient population at the Forensic Psychiatric Hospital is there under a finding of NCRMD—there is a large proportion of patients who are remanded for assessments or are receiving treatment, as they are unfit to stand trial. Therefore, the sample will include only those deemed NCRMD under s.16 of the *Criminal Code*. It is from this group of NCR accused persons in the forensic mental health services sector that the sample was selected, since a diagnosis and treatment of individuals will have already occurred.

Since this study is particularly concerned with the geographic distribution of NCR accused persons, the sample population included all those patients who received a conditional discharge from hospital during the timeframe of 1998 to 2003. This

timeframe was chosen because of the need to provide a follow-up period of at least one year for each case subject. Thus, someone who is discharged in late 2003 will still have the minimum follow-up period of one year and can be assessed until the end of 2004. Additionally, the conditionally discharged sample included only those who were released into British Columbia's lower mainland area, as an examination of rural locations is unfortunately beyond the scope of this study. For the purpose of this study, participants were determined to live in the lower mainland area if they were accessing services through the Surrey or Vancouver community clinics of the Forensic Psychiatric Services Commission (see Figure 2). If forensic patients were released into a geographic area that accessed any of the other clinics (the Prince George, Nanaimo, Victoria, or Kamloops clinics) as their primary community care centre, they were eliminated from the sample.

Figure 2: Locations of the Forensic Psychiatric Services Commission Outpatient Clinics and Inpatient Hospital



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This final sample is unrepresentative since it is drawn from a very specific population of forensic psychiatric patients who have been released on conditional discharge into the lower mainland area between 1998 and 2003. This group was identified through multiple sources owing to a change in records management systems in June 2000. Therefore, a search of the 'Cerner' and 'Alternate Database' records management systems at the hospital was undertaken for the period June 2000 to December 2003, as well as a review of all paper notices of review board hearings from January 1998 to May 2000. In this way, a complete sample of all conditionally discharged patients was established. After the identification of 261 patients who were eligible for inclusion in the population sample, a non-probabilistic random sampling technique was used to collect files for 117 male and female patients.

5.4 Quantitative Methods - Data Collection

In examining the hospital case records for patients in the sample, a category coding system was created to classify the information contained within hospital records. This technique provides a group of mutually exclusive, and exhaustive, categories by which a criteria classification system will emerge (Palys, 2003). The case files from the Forensic Psychiatric Hospital were coded under the five categories of variables outlined below.

5.4.1 Demographic Information

This category comprises information collected at admission including age, sex, marital status, education, employment status, ethnic group, financial support, type of residence, living arrangements, etc.

5.4.2 Mental Health and Legal Background

Mental health background includes previous contact with mental health services, previous hospitalizations, civil commitments, diagnosis at discharge, personality disorders, and assessments of psychopathy. Legal status was recorded for the three most serious charges of the NCRMD index offence, and included the charge, the *Criminal Code* section, the year of the charge, and some details surrounding the offence. These details included the involvement of drugs or alcohol in the offence, the accused's relation to their victim (in the case of personal injury offences), the total number of victims, and the weapon used.

5.4.3 Geography

Addresses were recorded at the time of admission (typically the same address as at the time of the offence), as well as addresses the accused persons were released to, up to three subsequent address changes after conditional release, and any periods of homelessness. Proximity to treatment services was also recorded by noting which FPSC clinic was involved in patient care before and after conditional discharge: this information was collected in order to assess the patient's proximity to mental health treatment and substance abuse treatment.

5.4.4 Returns to Hospital

Up to four returns to hospital were coded for each patient. Information collected includes the date of return to psychiatric inpatient care, the date of subsequent release from hospital, the reasons for return to hospital, the involvement of drugs or alcohol in the return, and the involvement of violent behaviour or violent victimization in the patient's return.

5.4.5 Review Board Decisions

The BC Review Board decisions for the sample were coded in order to assess the factors considered by the Board when making the decision to release a patient on conditional discharge. The following items were included: threat to public safety, threat to self, psychotic symptoms, treatment compliance, insight, substance abuse, location of release, social support on release, living arrangements, and proximity to treatment centre. The number of reviews that a patient underwent prior to the conditional discharge was recorded along with the date of discharge so as to calculate the patient's length of stay in

hospital. As well, the conditions as listed on the legal order are recorded in order to determine the frequency of conditions that have a geographic element or restriction.

5.5 Analytic Procedure

Once the file data was collected and coded from the patient sample files, it was entered into the analytical software program SPSS (Statistical Package for the Social Sciences). Within this program, data was analyzed using descriptive statistics, frequency charts, means tests, and multiple response sets. Additionally, differences between male and female characteristics were assessed using cross-tabulational analysis. This analysis will serve to answer the first research question regarding the characteristics of the NCRMD sample.

Information obtained in relation to residence and geographic factors was entered into a geographic information systems spatial mapping software program, ArcGIS. This program allows for the analysis of geographical elements of the data and enables a spatial map to be created in relation to locations of residence prior to hospitalization as well as patterns of residence after release. These maps and patterns were then analyzed in an attempt to determine whether there are areas of the lower mainland that receive significantly higher populations of forensic patients on conditional discharge. These maps also present the distribution of released patients who were returned to custodial care, and spatial clustering and patterning was analyzed.

Once spatial distributions were determined, the characteristics of the areas of high occupancy were examined. Stemming from a theoretical background in social disorganization and social ecology, I measured characteristics of social disorganization in

lower mainland communities through the use of aggregate census data such as demographic features, employment levels, community housing structure, etc. (Krieger et al., 2003). This data will provide insight into the neighbourhood-level features of social disorganization in these regions, and will aid in the process of inferring outside influences on the behaviour of patients who are released into those communities.

Review Board decisions were analyzed using descriptive statistics to determine the frequency with which the Board relies on various individual and environmental factors when ordering a conditional discharge. Thus, the frequency with which each factor is referred to was examined in order to determine the practical significance of environmental factors in release decisions.

The patient files were only accessed on site at the Forensic Psychiatric Hospital; therefore, the original information was kept secure within the Records Department of the hospital. Files were assigned a participant number at the time the information was coded, and any identifying information on the patient was kept separate from the other electronic information. All paper coding sheets were kept in a locked office for the duration of the study. Individual participant consent was not obtained, since the Forensic Psychiatric Services Commission granted general consent for the use of the aggregate data for research purposes. There were no means by which to identify the sample participants; therefore, further avenues for obtaining consent were not pursued.

5.6 Data Concerns

There are some concerns about what level of generalizations may be made on the basis of the results of the quantitative sample. The test sample of NCR accused will

employ non-probabilistic techniques since representativeness is not a concern. A purposive sample is optimal in order to ensure the presence of a conditional discharge disposition and the desired gender distribution. There is the risk that the purposive sample “reaffirm[s] rather than challenge[s]” the research objective (Palys, 2003) and does not reflect the true relationship between mental disorder and geographic patterns. The risk of obtaining biased information from this sample is reduced because the information comes from a secondary source (official records) rather than from the individual participant. Still, the purposive sample is necessary to obtain an adequate sample of individuals who are involved in the forensic mental health system and who have been released within the five-year period.

Finally, the reliability of the coding scheme used to analyze the patient records from the Forensic Psychiatric Hospital might have been compromised if the categories were not well defined (Palys, 2003). The consistency of the coding scheme was not influenced by the period between the event and the coding process, since the records could be revisited to verify consistency in the code. The number of categories for each variable was small and the nominal definitions of coded variables were clear so that the coder can have maximum reliability.

The issue of reactivity did not influence the validity of the quantitative portion of this study since there was no direct contact between researcher and participant; however, testing whether the methods were valid in measuring what they presumed to measure was always a concern. Given the focus on the graphical presentation of the data for analysis, the methods for sampling and data collection were adequate to answer the research questions.

5.7 Future Methodological Considerations - Qualitative Methods

It was the intention of this study to include a small qualitative interview sample to supplement the empirical study with more experiential data. This sample of interviewees was contacted by the Community Legal Assistance Society of British Columbia (CLAS), an agency that provides legal services for mental health consumers in conflict with the law. This agency contacted individuals who were absolutely discharged from the Forensic Psychiatric Hospital during recent years and supplied them with a research letter inviting them to participate in this study. Unfortunately, response to the interview letter was low, even after the addition of an offer to pay a participant stipend or honorarium. Alternative methods were applied to access this absolutely discharged population, by completing the interview immediately upon the client receiving an absolute discharge; however, only one interview occurred during the study period. As such, the interview cannot be used for the purpose of this thesis, but is included in a discussion of future research and policy directions in Chapter 6. Since one interview did take place, it is important to note the methodology that was to be used for all qualitative discussions.

Interviews would be semi-structured through the use of an interview questionnaire (Appendix F). The questionnaire asks each participant to reflect on his/her life subsequent to release from hospitalization, such as experiences with violence, substance use, and development of identity, as well as decisions regarding residence choices and geography. Themes and major issues would have been drawn from the transcribed interviews in order to assess the experiences of forensic mental health consumers in the greater Vancouver area.

Each interview would be audiotaped and take approximately 30 minutes to an hour. Throughout each interview, a lawyer from CLAS would be available to assist the participant if the interview process became emotionally difficult or if the issue of informed consent was questioned. Consent forms would be discussed with each participant and they would sign their consent prior to any interview questions being administered. Interviews would be transcribed and identified through a numbering scheme. Names and other identifying information would be kept separate from the numbered transcripts along with the participant consent forms. At no point during the research process would the raw data be shared with the participant's CLAS representative or anyone else not involved in the project. The only reason information might be released to others would be if there were any mention or discussion of imminent endangerment to another individual. All tapes and transcripts obtained during the research process would be kept securely in the office of the researcher, and the only individuals with access would be the researcher herself, and the research supervisor. It is also important to note that all tapes of the interviews would be destroyed immediately upon the completion of the project and all participants' identities, including any names given during the interview, would be kept in the strictest of confidence. All individuals participating would be given access to and copies of the final transcripts if they so chose and/or a copy of the final report.

As this was to be an exploratory research project with a very small sample size, there is no intention to generalize the findings. While realizing that interviews are limited by the potential for inaccurate memories, miscommunications or misunderstanding, it is nevertheless disappointing that this qualitative aspect of the research project was

unavailable at this time. However, while suggesting the need to complete a qualitative component to this research in the future, I am hoping to contribute theoretically and methodologically to the issues surrounding the release conditions of the forensic psychiatric population. The findings of this future research would hopefully assist community agencies such as CLAS who are directly involved in the lives of individuals on absolute discharge.

CHAPTER 6: RESULTS

6.1 Demographic Information

A brief demographic overview is herewith presented for the sample of 117 patients used in this study. Once they were found NCRMD, the subjects were either admitted to the Forensic Psychiatric Hospital (FPH) on custody orders or released on conditions into the community. If released, these clients received ongoing outpatient care from either the Vancouver or Surrey community clinics. Most of the sample from this study received custodial orders as an initial disposition and were, therefore, admitted to FPH after the finding of NCRMD.

Table 1: Admissions to Forensic Psychiatric Services after NCRMD

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	FPH	100	85.5	87.0	87.0
	Vancouver clinic	12	10.3	10.4	97.4
	Surrey clinic	3	2.6	2.6	100.0
	Total	115	98.3	100.0	
Missing	System	2	1.7		
Total		117	100.0		

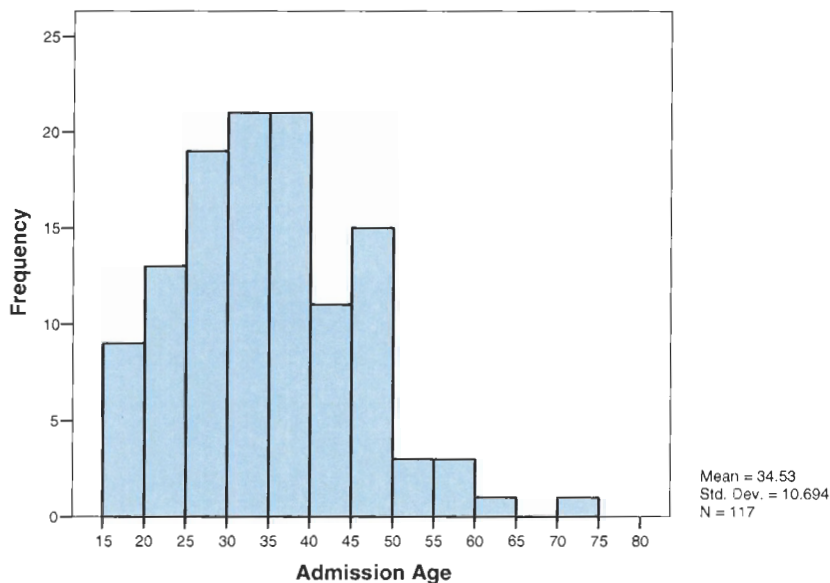
Research involving psychiatric populations indicates that, like in all criminal justice settings, men become involved in forensic systems at a much higher rate than women (Livingston et al., 2003). This finding is consistent with the sample in this study, where women are under-represented and comprise only 16.2% of the sample. As a result, generalizations about gender differences in this study will be limited.

Table 2: Sex of NCR Accused Sample (n=117)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	98	83.8	83.8	83.8
	Female	19	16.2	16.2	100.0
	Total	117	100.0	100.0	

For the purpose of this study, most admissions to hospital or a community clinic were made at the time of the NCRMD finding. There is a minority of cases where the admission age reflects the age at which the patient was transferred from another facility or another jurisdiction. The average age at the time of admission is 35 years but varies widely in age from 18 to 71. Although the spread in age is vast, it appears that entry into the forensic system occurs most frequently between 25 and 40 years of age.

Figure 3: Age of Admission to Forensic Psychiatric System



Research has shown that mental health clients have an increased risk of experiencing conflicted social relationships (Silver, 2002; Swanson et al., 1998; Esteroff, 1998). These social contacts come in the form of close relationships with spouses, family

members, and friendship networks. Therefore, it is important to explore the relationship demographics of the sample in order to explore the issues of conflict in relationships and social isolation.

Table 3: Marital Status at Admission

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Single	74	63.2	63.2	63.2
Married	9	7.7	7.7	70.9
Widowed	1	.9	.9	71.8
Divorced	22	18.8	18.8	90.6
Separated	8	6.8	6.8	97.4
Common law	2	1.7	1.7	99.1
Unknown	1	.9	.9	100.0
Total	117	100.0	100.0	

Almost 90% of the patients are without a formal spousal relationship at the time of admission, including 63.2% who are single, 18.8% who are divorced, 6.8% who are separated, and 0.9% who are widowed. This is a considerable number when considering the theorized social isolation that may accompany severe mental disorder. It is possible that these individuals are involved in romantic relationships that have not reached the stage of commitment to a spouse; however, this can be addressed in some part by examining the living arrangements of the subjects in the sample.

Table 4: Living Arrangements at Admission

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Alone	46	39.3	39.3	39.3
Spouse/common-law ⁶	15	12.8	12.8	52.1
Parents	18	15.4	15.4	67.5
Friends	8	6.8	6.8	74.4
Other relatives	8	6.8	6.8	81.2
Unknown	8	6.8	6.8	88.0
Other	14	12.0	12.0	100.0
Total	117	100.0	100.0	

As can be seen from this above table, the majority of patients live alone or live with a family member. It is interesting to note that, although the female sample is too small to make any definitive gender-based conclusions, female patients are currently involved in spousal relationships at a much higher proportion than the men in the sample, with almost half of the women living with a spouse or common-law partner.

Table 5: Cross-tabulation of Living Arrangements by Gender

	Gender		Total
	Male	Female	
Living with Alone	39	7	46
Spouse/common-law	7	8	15
Parents	18	0	18
Friends	8	0	8
Other relatives	6	2	8
Unknown	8	0	8
Other	12	2	14
Total	98	19	117

⁶ Living arrangements may differ from marital status even if the subject is in a spousal or common-law relationship. This difference may be accounted for by the method of data collection, where this demographic information is collected by a staff member upon initial admission to hospital. If the subject is unable to disclose their admission information due to their mental state at the time of admission, the admitting officer may leave this criterion blank. As a result, subjects may be described as married but their living arrangement was not known and therefore not recorded.

This finding of living arrangements and gender, while limited by the sample size, is consistent with the academic literature that explores targets of violence for men and women with mental disorders (Robbins et al., 2003; Hiday et al., 1998). These studies found that women act out more aggressively toward family members and partners as compared to men, who are more likely to act out against friends and acquaintances. The living arrangements of each gender can lend some understanding to their propensity to act violently toward different targets.

Table 6: Ethnic Background

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Caucasian	83	70.9	70.9	70.9
Aboriginal	4	3.4	3.4	74.4
Asian	8	6.8	6.8	81.2
East Indian	4	3.4	3.4	84.6
African	4	3.4	3.4	88.0
Unknown	3	2.6	2.6	90.6
Other	11	9.4	9.4	100.0
Total	117	100.0	100.0	

The sample in this study is limited in its ethnic diversity, with a significant majority of the sample being listed as Caucasian. Ethnicity was self-defined by patients at the time of admission; however, if a new patient was not in a state of mind to be able to comment on their own admission records, the admitting staff member either marked an observed ethnicity or left the criteria as ‘unknown’. It is possible that cultural variations account for some portion of this overrepresentation of Caucasian clients, as our understanding of mental disorder and psychiatric treatment differs across the world. The propensity to seek treatment via the forensic psychiatric system might not be as attractive an option for someone whose cultural traditions and beliefs are in contrast to Western

philosophies of medicine. Similarly, the involvement of family supports in the life of an individual with mental health issues can vary based on ethnic background and cultural traditions.

Unlike ethnic background, there seems to be more diversity in the sample with regards to the level of educational training they attained. It is important to note that the only educational endeavours included in the coding scheme are those that were started or completed at the time of admission. Any further education undertaken after admission to hospital was not accounted for in this analysis.

Table 7: Highest Educational Level

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Elementary	3	2.6	2.6	2.6
Jr. High	29	24.8	24.8	27.4
Sr. High	43	36.8	36.8	64.1
Post sec some	8	6.8	6.8	70.9
Post sec complete	3	2.6	2.6	73.5
Univ some	7	6.0	6.0	79.5
Univ complete	9	7.7	7.7	87.2
Tech/Trade	7	6.0	6.0	93.2
Vocational	2	1.7	1.7	94.9
Unknown	6	5.1	5.1	100.0
Total	117	100.0	100.0	

Approximately 30% of the sample continued with some form of training or education after leaving high school, with 7.7% completing a university degree, 7.7% receiving a technical or trade certificate, and 2.6% completing a college diploma. It should be noted that only the highest level of education was recorded: as such, certain educational details were excluded, such as earning multiple diplomas or entering a trade without completing high school.

Table 8: Employment Status at Admission

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Self	8	6.8	6.8	6.8
	Unemployed	85	72.6	72.6	79.5
	Employed F/T	7	6.0	6.0	85.5
	Employed P/T	5	4.3	4.3	89.7
	Seasonal	1	.9	.9	90.6
	Retired	2	1.7	1.7	92.3
	Student	3	2.6	2.6	94.9
	Unknown	3	2.6	2.6	97.4
	Other	3	2.6	2.6	100.0
	Total	117	100.0	100.0	

Employment for this sample is very low, with 72.6% of the sample being unemployed at the time of admission. Related to this statistic is the limited ability of those who are unemployed to support themselves financially in the community. The findings indicate that government support—through income assistance programs—is the main source of income for almost half of the subjects (48.7%). This income assistance category includes shorter-term unemployment insurance as well as disability payments for those who have been found so significantly impaired by their illness that they are unemployable.

Table 9: Financial Support at Admission

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No income	15	12.8	12.8	12.8
	Income Assistance	57	48.7	48.7	61.5
	Pension	4	3.4	3.4	65.0
	Employed P/T	1	.9	.9	65.8
	Employed F/T	8	6.8	6.8	72.6
	Supported by family	2	1.7	1.7	74.4
	Savings	4	3.4	3.4	77.8
	Unknown	21	17.9	17.9	95.7
	Other	5	4.3	4.3	100.0
	Total	117	100.0	100.0	

Finally, financial support in the community often reflects an individual's ability to maintain adequate housing when not in hospital. Looking at the residential arrangement a patient had at the time of admission, we can see that 40% of subjects were living alone in some capacity prior to their involvement in the forensic system.

Table 10: Housing Arrangement Prior to Admission

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Transient/no fixed address	11	9.4	9.4	9.4
Alone at SRO hotel	6	5.1	5.1	14.5
Alone at regular address	30	25.6	25.6	40.2
Spouse/common-law	13	11.1	11.1	51.3
With immediate family	21	17.9	17.9	69.2
With relatives	5	4.3	4.3	73.5
Boarding/Group home	7	6.0	6.0	79.5
Hospital	4	3.4	3.4	82.9
With friends/roommates	9	7.7	7.7	90.6
Unknown	6	5.1	5.1	95.7
Other	5	4.3	4.3	100.0
Total	117	100.0	100.0	

The group of 40% of the subjects who live alone includes 25.6% who were living alone at an apartment or house, 5.1% who were alone at a residential hotel or rooming house, and 9.4% who had no fixed address and were living a transient lifestyle. These last two categories are of particular interest because of the potential for individuals in this lifestyle to encounter law enforcement officials in their routine activities. Contact with the police can provide an avenue for these people to be charged criminally and, therefore, become involved with the forensic mental health system as opposed to having access to general mental health services.

6.2 Mental Health History

Individuals who encounter the forensic psychiatric system come from a variety of medical backgrounds, but typically have some history of mental health issues for the defence of NCRMD to be successful. Therefore, it was expected that the participants in this study would have experienced substantial involvement with either the general mental health or the forensic psychiatric systems. As anticipated, the vast majority (90.6%) of the sample had previous involvement with mental health services, either through outpatient services such as clinics and general medical practitioners, or through inpatient hospital treatment. Upon exploring this mental health history further, it was found that 70.9% of participants had been admitted for previous inpatient treatment in a civil (non-forensic) psychiatric facility. Inpatient admissions such as these include prolonged stays on psychiatric wards of general hospitals as well as admission to specialized psychiatric hospitals. In addition, 35.0% of the participants had previous inpatient admissions to forensic services, for both inpatient forensic assessments and hospitalizations. During the course of these previous and current involvements in the mental health system, 68.4% or 2 out of 3 participants had been civilly committed in order to provide them with inpatient care. It is evident from this high ratio of civil commitments that this group of participants can be considered severely mentally ill either prior to, or at the time of, their admission to FPH for their current offence.

After patients are admitted to hospital, they undergo a process of diagnosis and treatment by their treating psychiatrist. It is possible that the diagnosis may change over the course of the patient's stay in hospital as their illness responds to treatment; therefore, the diagnosis given at the time of discharge is the one that was recorded in this study. In

considering up to three diagnoses for each participant, it appears that the major psychiatric features of this sample are the presence of schizophrenia or another psychotic disorder (present in 81.7% of the sample) as well as substance abuse or a substance-induced disorder (including substance-induced psychoses), as seen in 55.7% of the patients.

Table 11: Psychiatric Diagnosis at Discharge (Multiple Response)

		Responses		Percent of Cases
		N	Percent	
All Discharge Diagnoses Condensed	Disorder Diagnosed in Infancy	8	3.1%	7.0%
	Delirium, Dementia, etc	2	.8%	1.7%
	Substance-Related Disorder	64	24.9%	55.7%
	Schizophrenia or Psychotic Disorder	94	36.6%	81.7%
	Mood Disorder	22	8.6%	19.1%
	Anxiety Disorder	3	1.2%	2.6%
	Sexual Disorder	3	1.2%	2.6%
	Personality Disorder	36	14.0%	31.3%
	General Medical or Social Condition	14	5.4%	12.2%
Deferred or No Diagnosis	11	4.3%	9.6%	
Total		257	100.0%	223.5%

Personality disorders were diagnosed in relation to 31.3% of patients in the sample: Antisocial Personality Disorder or Traits were identified in 53% of the patients with personality disorders or 7.4% of the total sample. While not as high as the Abram & Teplin (1991) study, the results of this analysis still show a high co-occurrence of substance use disorders and personality disorders with other psychiatric illnesses. Interestingly, only two subjects out of the entire sample were identified as being psychopathic. This is unusual based on the proportion of participants who were

diagnosed with a personality disorder. It is possible that the data on psychopathy is incomplete, since psychological testing records, including the results of any scored PCL-R tests, were not available to this researcher. Likewise, it is not standard for the PCL-R to be administered with all patients entering forensic care. Of note, patients with previous criminal justice experience outside the forensic system may have records with other agencies relating to their scores on psychopathy assessments; however, these assessments were not included as a part of the hospital records examined in this study. As a result, notations on the standard medical charts with relation to psychopathy were the only source of data for this variable.

6.3 Legal Status

The NCRMD offences that resulted in involvement with the forensic system are quite varied, ranging from weapons offences and mischief to sexual assault and murder. Up to three charges relating to the finding of NCRMD were recorded, allowing for the analysis of more than multiple charges stemming from the same criminal event. The most common charges for an NCRMD offence are the three levels of assault found in two thirds of the sample: 17.9% of the patients were charged with assault, 36.8% were charged with assault with a weapon or causing bodily harm, and 12% were charged with aggravated assault. This distribution was remarkably similar for men and women, with assault charges found in the criminal charges of 37.2% of males and 37.8% of females. It is interesting to reflect upon the distribution of these three levels of assault, where a large proportion of the sample was charged with the more serious offences of assault causing bodily harm or aggravated assault. Individuals entering the forensic system are usually not provided the benefit of a plea bargaining option, and are, therefore, likely to have

their charges remain at the higher levels of seriousness. Accordingly, we do not see the same distribution of simple assault charges as might be seen in non-forensic populations who have access to plea negotiations. The next most common charges against patients were that of murder/attempted murder (25.7% of cases), criminal harassment/threats (24.8% of cases), mischief (10.3% of cases), and sexual offences (9.5% of cases). It is important to note that the sexual offences were only committed by male subjects and are a conglomeration of sexual assault, sexual assault with a weapon, sexual interference, child pornography, and indecent acts.

In looking at the selection of victims involved in the NCRMD offences, the findings of this study support the literature regarding intra-familial violence for women and extra-familial violence for men (Robbins et al., 2003; Hiday et al., 1998). As seen in Table 12, female patients exhibited their violent actions against relatives in 33.3% of the charges and against the category of 'other' (which includes spouses and treatment staff) in 23.8% of cases. Male subjects showed a much greater propensity to be charged for violent acts against friends and acquaintances as compared to the females in this sample. Violent acts against police officers was exclusively found in the male participants, which is an important issue when considering the likelihood of women to access the forensic system versus the general mental health system. It is possible that police are more likely to charge a mentally ill male with a criminal offence as opposed to diverting them to the mental health system if they themselves experience a violent attack by this mentally ill person at the time of contact. This research question is beyond the scope of this study, but would be interesting to explore it further in light of these preliminary findings.

Table 12: Crosstabulation of Relation to Victim by Sex (Multiple Response)

			Sex		Total
			Male	Female	
relation to victim all	Stranger	Count	24	5	29
		% within sex	20.3%	23.8%	
	Police Officer	Count	14	0	14
		% within sex	11.9%	.0%	
	Friend/Acquaintance	Count	41	4	45
		% within sex	34.7%	19.0%	
	Relative	Count	28	7	35
		% within sex	23.7%	33.3%	
	Other	Count	10	5	15
		% within sex	8.5%	23.8%	
	Unknown	Count	1	0	1
		% within sex	.8%	.0%	
Total		Count	118	21	139

Percentages and totals are based on responses

The incidence of weapons offences in this sample appears to be related to ease of access to these items. A knife was the most common weapon involved in the violent charges for this group (37.4% of cases), while the use of hands or bodily force came as a close second (33.0%). The remaining weapons used in the NCRMD offences were a gun (9.6%), a blunt object (8.7%), and other weapons such as fire, vehicles, etc. (8.7%). These violent offences involved a mean of 1.57 victims, with 65.8% of the sample having only one victim.

Based on the information that was included in official hospital records, the use of drugs or alcohol was a factor in one third of the events leading to an NCRMD finding. However, there were a further 21.4% of participants for whom no information could be deciphered either confirming or refuting the influence of substance use in their criminal offences.

Table 13: Under the Influence of Drugs or Alcohol for NCRMD Offence

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	39	33.3	33.6	33.6
	No	52	44.4	44.8	78.4
	Unknown	25	21.4	21.6	100.0
	Total	116	99.1	100.0	
Missing	System	1	.9		
Total		117	100.0		

6.4 Review Board Hearings

Participants in this study had an average of 3.25 Review Board hearings prior to being granted a conditional discharge. This includes the initial disposition hearing held by the Review Board or court after a finding of NCRMD. From the time of admission to the time of release, participants stayed an average of 32.8 months or 2.7 years before being conditionally discharged.

6.4.1 Conditional Discharge Orders

A content analysis was undertaken in relation to the clauses found in each Review Board order for a conditional discharge⁷. This analysis shows that there are certain clauses that appear in most discharge orders (which I termed ‘primary conditions’), some that appear in a large amount of orders but not in all (‘secondary conditions’), and others that appear rarely (‘tertiary conditions’). The divisions between the three tiers of conditions were based on the natural groupings that developed in the analysis. Seven conditions appeared in 99.1% to 100% of cases, accordingly these have been termed the primary conditions. They include a supervision clause, an approved residence clause, an outpatient treatment clause, a return to hospital clause, a prohibition of weapons clause, a

⁷ See Appendix A for clauses considered in conditional discharge orders.

good behaviour clause, and a reporting to the Review Board clause. These conditions appear to constitute the fundamental framework of a conditional discharge order and presumably capture the essence of what the Review Board considers important in releasing all NCR accused persons from hospital.

A grouping of secondary conditions appeared for between 65.5% and 75.9% of the orders. There are only three conditions fitting into this category; however, they all relate to substance use and its prohibition in the community. Specifically, there is a clause prohibiting the use of alcohol and/or hallucinogens and another prohibiting the use of non-prescription drugs without medical approval. The third clause allows for the Director of the hospital to monitor the released person's compliance with the two previous substance use clauses by testing for unapproved substances. This testing clause is interesting to note in light of the British Columbia Court of Appeal decision in *R. v. Shoker* (2004), which challenged the constitutionality of a probation condition that the accused submit to a demand for bodily substances and found that it violated s.8 of the *Charter* (the right to be secure from unreasonable search and seizure). It is possible that similar *Charter* arguments could be brought forward regarding Review Board conditional discharge orders, especially if the hospital cannot show that they had reasonable and probable grounds for suspecting that the accused breached their abstention condition. However, at this time, the decision is not binding (see *R. v. Williamson*, 2005) and substance-testing clauses continue to appear in Review Board orders. Substance abuse appears to be a recognized issue within Review Board decisions since it is included in between 66% and 75% of all conditional discharge orders. Based on the magnitude of research that examines the relationship between mental disorder and substance abuse (see

Brink et al., 2001; RachBeisel et al., 1999; Vanable et al., 2003; Virgo et al., 2001; WHO, 2004), it is refreshing to note that the Review Board is incorporating these ideas into their examination of risk factors for NCR accused.

Finally, tertiary factors that were included Review Board decisions appeared in less than 25% of the discharge orders. These typically include specialized administrative clauses that relate only to that particular NCR accused, but two clauses appeared with more frequency than the others and warrant further discussion. One tertiary clause appearing in 23.3% of cases is an order directing no contact with particular individuals, the other clause appearing in 14.7% of cases directs that the accused is not to travel to certain geographic areas of British Columbia. Typically, these clauses relate to non-contact with the victims of the NCRMD offence and geographic regions such as city blocks to avoid the victims. These geographic restrictions tend to be for the protection of the public and the peace of mind of the victim as opposed to the needs of the NCR accused. They usually reflect the avoidance of an area in which the victim lives or frequents, but is not used to restrict the movement of an accused to an area that may be less suitable for their successful reintegration. Therefore, when the Review Board considers geography in conditional discharge orders, it is primarily concerned with the prevention of future encounters between the NCR accused person and the victim.

6.4.2 Review Board Decision-Making

The reasons for judgment of each conditional discharge order were reviewed in order to ascertain what types of factors the Review Board takes into consideration when releasing an NCR accused person. After an initial appraisal of reasons for judgment on six files, ten factors for discharge were identified. These factors reflect some common

issues that were known to have been discussed by the Review Board in their written judgments, as well as other additional issues that are important to this project but whose presence in Review Board decisions was not known. Through the form of a short content analysis, the presence or absence of the following reasons for judgment were noted in each document:

Table 14: Review Board Reasons for Judgment

	Yes	No
Threat to public safety	110 (99.1%)	1 (0.9%)
Threat to self	11 (9.9%)	100 (90.1%)
Presence of psychotic symptoms	106 (95.5%)	5 (4.5%)
Expected treatment compliance	100 (90.1%)	11 (9.9%)
Insight into illness	88 (79.3%)	23 (20.7%)
Substance abuse	81 (73.0%)	30 (27.0%)
Geographic location of release	37 (33.3%)	74 (66.7%)
Social support upon release	90 (81.1%)	21 (18.9%)
Living arrangements	103 (92.8%)	8 (7.2%)
Proximity to treatment centre	9 (8.1%)	102 (91.9%)

As expected, threat to public safety is a critical variable (99.1% of orders) considered by the Review Board when making the decision to release one of the NCR accused in this sample. This finding is supported by the fact that Review Boards have been mandated to consider the issue of significant threat through such decisions as *Winko* (1999) and *Orlowski* (1992). Similarly, the Review Board's reliance on factors related to an individual's acute symptoms and treatment compliance are understandable and anticipated since this patient is undergoing psychiatric treatment in hospital. The Review Board is required to consider whether the same level of treatment and care can be managed in the community through outpatient services; therefore, the presence of active symptoms becomes a consideration of risk. For the contextual and geographic factors, results show that living arrangements are a significant factor taken into consideration

when releasing an NCR accused but the specific location of that residence is not an equally crucial variable. When geography was considered in the reasons for judgment, it was primarily within the context of areas to avoid based on victims' residences. There were only three judgments in which geographical issues were discussed in the written reasons relating to the suitability of a neighbourhood for the accused to live in. In one case, the Review Board discussed an accused's history of committing his second NCRMD index offence while on visit leave to a hotel in downtown Vancouver⁸ where a combination of non-prescribed and street drugs played a role in his offence. Another set of Review Board reasons discussed appropriate locations of residence and stressed the need to avoid the Downtown Eastside of Vancouver due to the potential exposure to illegal substances⁹. Lastly, one judgment explores the choice faced by an accused person when selecting a residence with minimal income¹⁰. Low-income areas, such as Mount Pleasant and the Downtown Eastside of Vancouver, become an attractive residential option upon leaving hospital, in part due to the low-cost housing available there.

⁸ Study number 104, Reasons for Judgment May 1, 2003. The Review Board discusses "...while on visit leave...the accused committed his second index offence, an assault with weapon and an assault causing bodily harm on a co-resident of his [Single Room Occupancy] SRO hotel in downtown Vancouver. Shortly thereafter he was readmitted to FPH with a diagnosis of schizoaffective disorder in a manic episode". (p.3)

⁹ Study number 101, Reasons for Judgment July 31, 2000. The Review Board states "The Hospital seems supportive of that approach and has indicated that they will be working closely with the Outpatient Clinic in this regard to ensure that whatever independent living accommodation you do take up is in an appropriate setting, for example, it is not in the downtown east side where you could be more vulnerable and exposed to drugs and alcohol. At this stage, your continued residence [] is deemed appropriate until such time as appropriate independent living can be set up". (p. 4)

¹⁰ Study number 69, Reasons for Judgment October 23, 2001. The Review Board wrote "The evidence given this morning...indicates that you have chosen a place partly because of cost. You don't have a large amount of money available to you. But the Hospital is satisfied that the place is a satisfactory place for you. It gives you a certain amount of privacy and allows you to cook your own meals. It is close to the downtown east side, which is not necessarily a good thing, but so far at any rate you have indicated that you are able to stay away from the attractions of drugs and drug pushers and so forth. That is extremely important as far as your progress and success in dealing with your problems are concerned". (p.5-6)

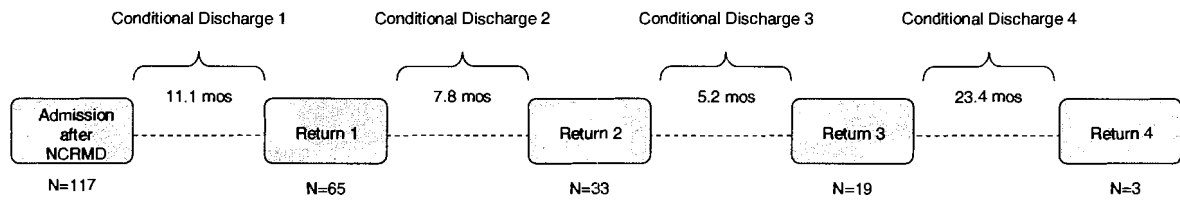
6.5 Returns to Hospital

Upon release from hospital, the participants were either under the jurisdiction of the Surrey or Vancouver community clinics. Based on the random sample selected, 73 subjects (62.4%) were released into the region served by the Vancouver clinic, including Richmond, Vancouver, Burnaby, and the cities to the north of Vancouver. There were 44 subjects (37.6%) sent to the Surrey clinic covering the areas of New Westminster, Surrey, Coquitlam, Abbotsford, and Langley. During the course of the five years studied in this project, many patients returned to hospital from the community after their conditional discharge. Reasons for these returns are explored below.

6.5.1 Time in the Community

After an initial conditional discharge from FPH, a number of patients in the sample experienced further returns to inpatient care along with subsequent discharges again into the community. Approximately half of the sample returned to hospital at least once after they were conditionally discharged by the Review Board. Between the date of conditional discharge and the first date of return, subjects were in the community for an average of 11.1 months. That means that, after almost a year in the community, nearly half the sample (65) encountered some type of difficulty in their reintegration that required a return to custodial care (see Figure 4).

Figure 4: Average Time on Conditional Discharge before Returning to Hospital



Upon re-release, half of the returned group came back to hospital again. That is, 33 of the 65 subjects came back to inpatient treatment a second time, with this return taking place an average of 7.8 months later. Community placements continued to be more successful as time passed, as can be seen by the incremental diminishing of third and fourth returns to hospital. Only 19 subjects returned to hospital a third time, and did so an average of 5.2 months after their last community release. Fourth returns to hospital were rare in this sample. However, the length of follow-up varies for each participant: therefore, the possibility of future returns may be unaccounted for in the more recently released subjects. Table 15 displays this data in more detailed form.

Table 15: Time spent in the community before returning to hospital (in months)

	Conditional Discharge to Return 1	Discharge 1 to Return 2	Discharge 2 to Return 3	Discharge 3 to Return 4
N Valid	65	33	19	3
Mean	11.1	7.8	5.2	23.4
Median	7.6	4.5	2.9	10.5
Std. Deviation	9.6	8.6	5.7	24.7
Minimum	.0	.2	.1	7.9
Maximum	44.7	40.1	21.7	52.0

6.5.2 Time in Hospital

When NCR accused persons in this sample were returned to hospital, they spent an average of 137 days in hospital before being released again. In each case, the returns

to hospital lasted between an average of four to six months; however, for three subjects, the return to hospital was indefinite as they were not released by the end of this study.

Table 16: Time Spent as Inpatient upon Return to Hospital (in days)

	N	Minimum	Maximum	Mean	Std. Deviation
Return 1 to Discharge 1	63	1.00	1420.00	137.4762	233.59117
Return 2 to Discharge 2	32	5.00	1176.00	210.0625	313.34614
Return 3 to Discharge 3	15	3.00	560.00	115.4000	183.71204
Return 4 to Discharge 4	3	4.00	463.00	157.6667	264.42831
Valid N (listwise)	3				

6.5.3 Reasons for Return

The reasons for return were recorded from the admission chart and coded according to four major variables that were identified: breached conditions of the Review Board order, psychiatric decompensation or diminishment in functioning, new criminal charges, and other reasons.

Table 17: Reasons for Return to Hospital (Multiple Response)

		Responses		Percent of Cases
		N	Percent	
Reason for Return All	Breach Conditions	32	27.8%	50.0%
	Decompensation	69	60.0%	107.8%
	New charges	6	5.2%	9.4%
	Other	7	6.1%	10.9%
	1 & 2	1	.9%	1.6%
Total		115	100.0%	179.7%

Substance abuse was noted as being conclusively involved in 39 returns to hospital, making it a factor in 59.9% of all returns to hospital or for 33.7% of the subjects. These results fall within the spectrum of substance use and psychiatric illness literature, between Brink et al.'s (2001) suggestion of an 82% comorbidity rate and Virgo et al.'s (2001) study finding a 20% relation between mental illness and problematic substance use. This sample is demonstrative of the confounding effects produced when combining mental disorder and substance use in the community, since it is noted as a factor for returning to hospital in this group. The substance use either became an issue because of breached conditions or was deemed a sufficiently significant factor in the maintenance of the patient's mental well being that the decision was made to revoke the conditional discharge.

Finally, the use of violence as a reason for return was noted in 35.4% of all returns to hospital. Therefore, violence was a factor for 19.8% of patients in the sample regarding their behaviour in the community. These findings are noteworthy in light of Hodgins et al.'s (2003) study relating to aggression and perception of threat, since they found that subjective impressions of threat combined with acute psychotic symptoms increased the risk for aggression and violence in people with severe mental illness. When looking at the prevalence of violence as a factor in returns to hospital, it is critical to appreciate this within the context of the 69 returns to hospital that were due to psychiatric decompensation. If these individuals were experiencing increased symptoms of their illness and decreased functioning in the community, based on Hodgins et al.'s (2003) research, it is not unexpected to also find an elevated level of violence in the group of returnees.

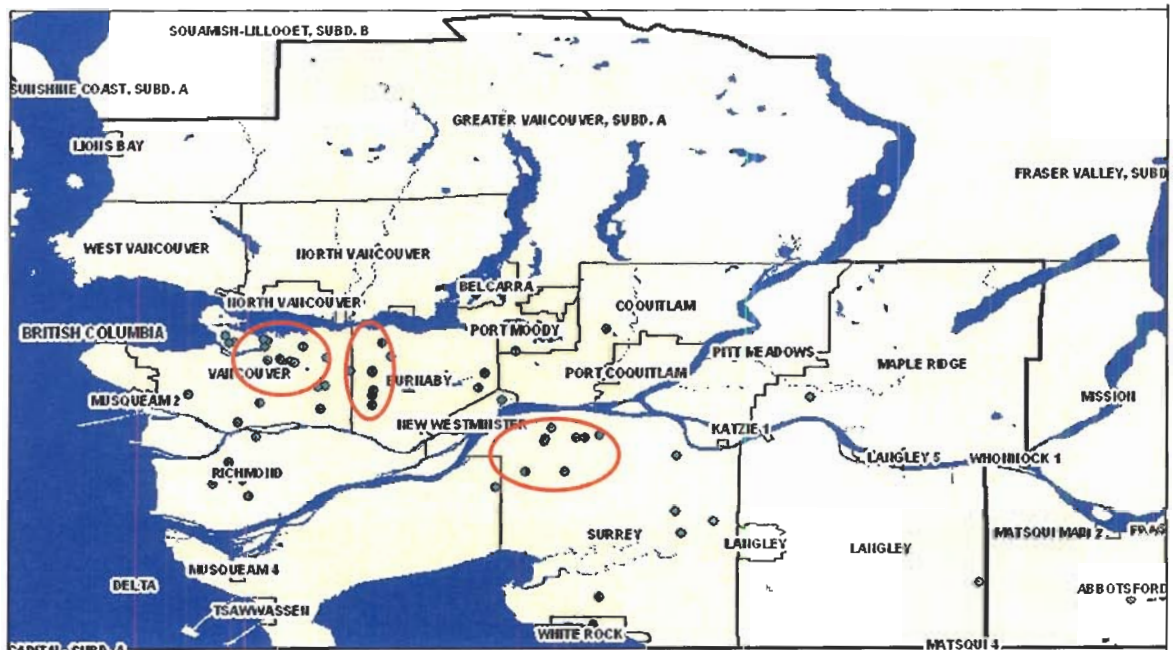
6.6 Spatial Distribution

After having explored the reasons for return, the findings suggest that breach of conditions, psychiatric decompensation, substance use, and violence are all key variables in understanding the successful reintegration of NCR accused in the community.

Determining the spatial distribution of the areas to which this sample was released will assist in comparing the concentration of these key variables to the residential neighbourhoods of released forensic clients.

Figure 5 represents the addresses of NCR accused at the time they were first admitted to forensic care. Each green marker represents one client's address at the time of admission if that address is in the lower mainland area of British Columbia. Out of the 117 subjects in this study, 44 admission addresses could not be geocoded. Of the group of non-geocoded addresses, 35 were addresses that were either outside the geographic boundaries of the lower mainland or were in another province, and nine clients were of no fixed address prior to being admitted to the forensic hospital. Those who had a residence in the requisite area of southern British Columbia are included in the map below.

Figure 5: Spatial Distribution – Areas of Residence at Admission



There is a wide spread of residences at the time of admission, with three notable clusters of points in three city areas (circled in red in Figure 5). These clusters are in the regions of East Vancouver, West Burnaby, and North West Surrey. Community names for these regions are Downtown Eastside/Strathcona/Mount Pleasant in Vancouver, West Central Valley/Willingdon in Burnaby, and Whalley/Guildford in Surrey. Appendix B includes maps of each urban area broken into community regions.

Figure 6: Spatial Distribution – Areas of Residence upon Conditional Discharge



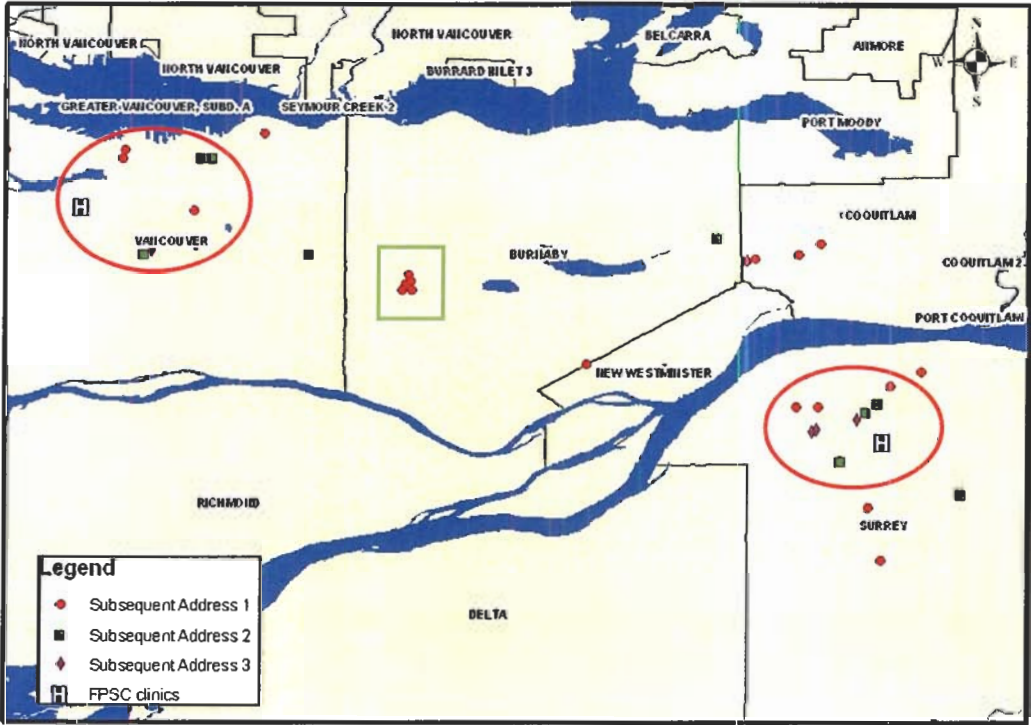
Figure 6 illustrates the residences of the subjects when they were first released on conditional discharge. The larger points represent multiple subjects at the same residence, and increase in marker size with the number of individuals at that residence. The two largest repeat addresses are highlighted with arrows marking point 'A' and point 'B'. Point 'A' represents Willingdon House, a transitional residential facility that is an exclusive partner of the Forensic Psychiatric Services Commission (FPSC). Its purpose is to bridge the residential change from hospital to community living. From the selected subjects who were released between 1999 and 2003, 19 patients had their initial residence at Willingdon House upon discharge from hospital. Point 'B' is located at Riverview Hospital, the civil psychiatric hospital for patients accessing services under the general mental health system. This repeat address location represents the forensic cottages program, a transitional housing program run through the FPSC to provide a gateway into community living. Eight patients in this sample resided at the forensic cottages at the time of their initial conditional discharge. Other smaller repeating addresses are boarding homes and group homes, and appear in Surrey, Vancouver, and Abbotsford.

Larger images of the areas surrounding the Surrey and Vancouver clinics appear in Appendix C. The two psychiatric clinics are marked by white 'H' icons and are located in the neighbourhoods of Whalley in Surrey and Mount Pleasant in Vancouver. Based on these maps, residences appear to cluster lightly around the area of the Vancouver clinic and Surrey clinic; however, this clustering is not entirely reliable due to the inclusion of 25% of patients who are in FPSC transitional facilities. Nevertheless, the remaining 75% of participants who reintegrated directly into independent community placements demonstrate a definite trend towards repopulating the communities from which they came. According to admission maps, the neighbourhoods of Mount Pleasant (Vancouver) and Whalley (Surrey) are communities that originally house individuals who enter the forensic system and, likewise, subsequently house the same clients when they leave hospital. However, inferences concerning the attraction of such neighbourhoods are limited since a substantial number of participants remained in FPSC-run community facilities in Burnaby and Coquitlam. Therefore, it is necessary to examine the subsequent addresses of the released patient population in order to ascertain the migration pattern of patients after they leave their initial transitional housing placements.

Changes in residences were recorded for a minimum of one year past the end of the study period (i.e. 1999 to 2004). This resulted in the follow-up period being variable for the sample, with some participants being tracked for up to 5 years while others were only tracked for one year. Up to three address changes were recorded for each subject and were mapped according to the chronology in which they happened. The map of subsequent addresses shows a definite clustering of addresses around the Surrey clinic in Whalley with a more modest grouping of addresses around Vancouver's clinic.

Movement into Whalley from other communities seems to happen more frequently after the initial conditional discharge, as seen through the increase in clustering in Figure 7 compared to Figure 6.

Figure 7: Subsequent Address Changes 1999-2004

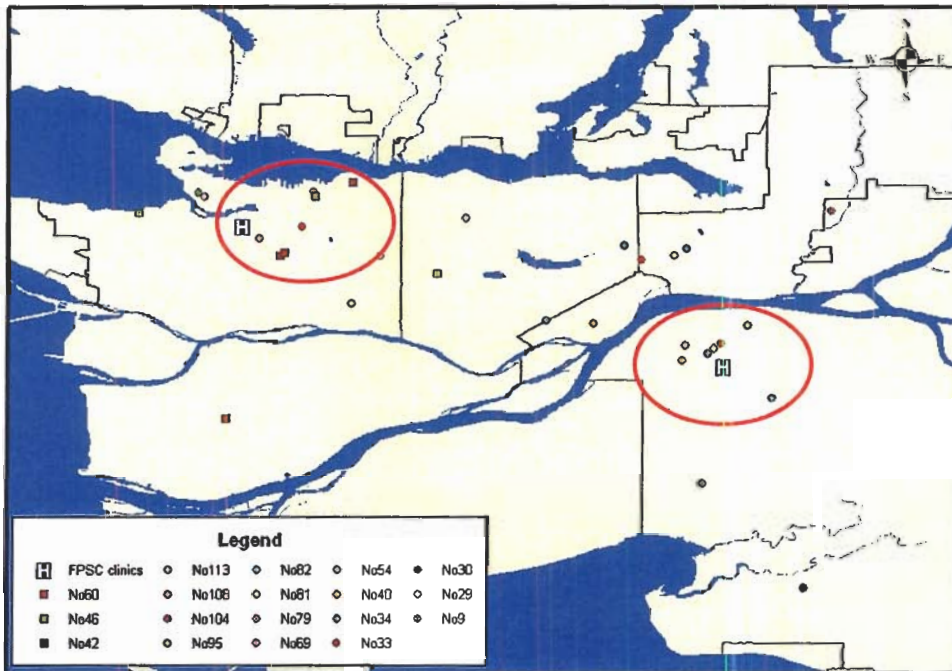


As is the case with their initial conditional discharges, many subjects were again released to Willingdon House upon their subsequent discharge (highlighted in Figure 7 with a green square). This community treatment facility remains a frequently used residence for transition into the community, especially after a return to inpatient care.

In order to properly assess the relationship between the spatial distribution of residences and the frequency of returns to psychiatric care, subjects were selected from the total sample who returned to the hospital three or more times. This procedure was used in order to select only those patients who had to return to inpatient care with greater

regularity than the rest of the population. By studying the residential patterns of this select sub-sample of 19 subjects, the correlation between area of residence and returns to hospital is better understood. The residential mobility patterns of the sub-sample are illustrated in Figure 8, with a different colour and marking denoting the various addresses of each released patient. Square markings are those participants who had four returns to hospital after conditional discharge, and circle markings are the subjects with three returns to hospital. As had been seen for the entire sample of 117, this sub-sample of frequent re-hospitalizations shows definite grouping around the North Surrey and East Vancouver regions, especially around the areas of the FPSC clinics. Patients who return most often to hospital are primarily living in Surrey's Whalley and Vancouver's Mount Pleasant communities within close proximity to outpatient forensic services. This pattern is most prominent for the Surrey region. Possible explanations for the increased re-hospitalizations in certain neighbourhoods lie in the characteristics of these communities.

Figure 8: Spatial Distribution: Sub-sample of NCR Accused Persons with 3+ Returns to Hospital – Movement Patterns of Residence by Individual Study Number



The above spatial distributions denote four geographic regions that are significant in the release patterns of NCR accused persons in this study: Mount Pleasant/Downtown Eastside in Vancouver, Willingdon Heights in Burnaby, Cape Horn in Coquitlam, and Whalley in Surrey. When analysing the communities that attract NCR accused who do not reside at FPSC transitional facilities, two key regions are evident. Mount Pleasant/Downtown Eastside in Vancouver consistently appears as a clustered area for residences both prior to involvement in the forensic psychiatric system as well as after release from inpatient care. Correspondingly, this same trend is seen in Surrey’s Whalley neighbourhood, although movement into this region is somewhat delayed until subsequent address changes. However, findings suggest that this region receives the most unsuccessful community placements—unsuccessful in that the placements are transitory and the NCR accused eventually returns to hospital multiple times. In order to understand

the characteristics of these significant communities, especially within the construct of social disorganization principles, it is necessary to give a brief overview of census demography for each neighbourhood.

6.7 Neighbourhood Census Comparisons

Using data from the 1996 Canadian Census, various socioeconomic measures are presented herewith in order to gain further insight into the features of the communities where NCR accused persons are residing. The strategy for selecting these particular Census variables stems from the suggestions outlined in Krieger et al's (2003) description of methodological approaches to geocoding socioeconomic measures for health studies. In line with their suggestions, measures of unemployment, income, poverty, education, and rental households were included in the Census comparison at the census tract or neighbourhood level (Krieger et al, 2003). Further, variables stemming from traditional measures of social disorganization were included, such as ethnic diversity and unattached marital status (Shaw & McKay, 1969). Chloropleth maps of Lower Mainland British Columbia are presented in Appendix D for each of these measures.

6.7.1 Unemployment

Results of the census comparison depict that the majority of the employable population (i.e. 15 years and older) living in Lower Mainland British Columbia are, in fact, demonstrating low levels of unemployment. However, the unemployment rate is significantly higher in the areas of East Vancouver and North-West Surrey than they are in other regions. These are the same areas in which NCR accused persons were found to reside upon leaving hospital care.

6.7.2 Income

Average individual income levels also appear to be significantly lower in East Vancouver and North-West Surrey communities when compared to other surrounding regions. Most notably, both of these districts show average individual incomes as below \$25,000; quite a marked difference from the more common average income of \$30,000 to \$70,000 earned in adjoining communities. The relatively low income levels are quite noticeable on the choropleth map and appear most strongly in the Mount Pleasant and Whalley neighbourhoods.

6.7.3 Poverty

According to Census data, the areas with the highest percentage of low-income family units are East Vancouver, North Surrey, and North Richmond. Low income designation is determined by Federal Census regulations, and is reserved for households whose income falls below a standard set by the Federal government. Therefore, forensic patients who are leaving hospital custody are also typically entering communities that house an elevated proportion of low income families.

6.7.4 Education

Measures of education included in this comparison pertain specifically to low education, or those individuals whose highest educational achievements were below the high school level. Results of the census comparison show that the highest concentrations of the population who is 15 years or older and have less than grade nine education are in East Vancouver and North-West Surrey. As with the other measures of socioeconomic

deprivation, low education appears most condensed in the communities where NCR accused persons are residing upon release.

6.7.5 Rental Accommodation

Inferences into the levels of wealth or assets owned by community residents can be made through an exploration of the proportion of rental accommodations versus owner-occupied homes in a community (Krieger et al, 2003). As such, the neighbourhoods in North-East Vancouver show the highest concentration of rented accommodation in the Lower Mainland region. While rental accommodation alone does not infer a socially disorganized neighbourhood, it does speak to the frequency with which a community will experience residency turn-over. Consequently, forensic patients who choose to reside in East Vancouver are choosing communities with high occupancy turn-over and the possibility of lower social investment by community residents.

6.7.6 Ethnic Diversity

The two maps of ethnic diversity show that while there are a large variety of communities where visible minority residents predominate, the same cannot be said for the residential location of the Lower Mainland's Aboriginal population. Self-defined Aboriginal peoples are indeed living predominantly in East Vancouver; where levels of unemployment, low income, low education, and rental accommodation are most elevated. NCR accused persons are likewise entering this same community region, where these above-mentioned measures of socioeconomic deprivation are present.

6.7.7 Single or Unattached Occupancy

Not unexpectedly, the map of single occupant housing closely mirrors the map for rented accommodation, with North-East Vancouver showing the highest concentration of unattached resident population. Thus, released forensic patients are entering communities with smaller established family populations and with higher rates of unattached male and female residents. On average, social contact for the residents of these areas will be less likely to come from immediate family ties, because of the lower incidence of individuals living in family structures. Overall, these results suggest that social networks of NCR accused persons residing in these communities may develop from extra-familial sources such as friends and treatment team members.

CHAPTER 7: DISCUSSION

The results of this study show how geographic characteristics are currently involved in release decisions for NCR accused persons as well as the spatial patterns created by conditional discharges in lower mainland British Columbia. The findings demonstrate how geographic factors and spatial characteristics can be included in mental health research, and that these factors are particularly relevant for the release of forensic populations. The implications of the results of this study are threefold; results show consequences for treatment, proposals for policy, and directions for future research initiatives.

7.1 Consequences for Treatment

It is common practice for hospital staff to be involved in the development stage of release plans for NCR accused before they are granted a conditional discharge. Most often, patients who are under custodial orders are released on visit-leave passes into the community for some time before being deemed an appropriate candidate for a conditional order. This term placement allows staff to determine how a client is going to integrate into society while being an outpatient, but still lends the hospital a degree of control over the intensity of exposure to community influences. Visit leaves, if successful, often lead to a recommendation for a conditional discharge, since the forensic patient has shown their ability to integrate well into outpatient living. It is at this stage that the results of this study begin to resonate. The forensic treatment team aids in the residential placement of an accused, often by either referring them to a transitional facility (such as Willingdon

House as seen in the results chapter) or by approving independent living residences chosen by the accused. However, it appears that the location of such an approved residence is not yet considered a part of a treatment release plan. Therefore, the results of this study bring to light the difference between approval of residence and approval of *location* of residence. The minor consideration given to geographic factors is evidenced by the Review Board's reasons for judgment. Although the results of this analysis represent only the written reasons and do not capture the intricacies of the oral discussions naturally occurring between Board members, they still show reliance on individual-level factors for decision-making. The broader contextual influences that affect released NCR accused persons are not yet considered with any credence as compared to individual risk and treatment issues.

Subjects in this study drifted into North-East Vancouver and North-West Surrey after leaving the hospital, with this drift becoming more pronounced the longer an accused was tracked. This pattern is especially pronounced for individuals who frequently return to hospital and suggests a correlation between some aspect of these residential neighbourhoods and the propensity to return to hospital after an unsustainable placement in the community. Therefore, results suggest that treatment teams should look at the features of placement neighbourhoods that may negatively influence the treatment and successful reintegration of a newly released forensic client. By addressing external community-level factors when creating an outpatient treatment and release plan, team members have the opportunity to proactively confront and manage the potentially stressful aspects of reintegration into independent living. Treatment teams will have a fuller understanding of the natural external stressors present in each community setting,

so that efforts can be focused to address any arising issues such as alcohol and drug access, housing, interpersonal contact/isolation, crime, violence, etc.

Substance abuse was highlighted in various elements of the results as an important variable for many forensic patients. Not only did drug and alcohol issues frequently constitute a significant factor in the NCRMD charge, but they were also a strong diagnostic criteria on discharge from hospital, with 55.7% of patients having a comorbid substance use disorder. Critical to the understanding of this finding is the recognition that the concurrent substance-use disorder was still deemed to be an active diagnosis at the time of release, thereby creating an additional obstacle for an NCR accused person to manage successfully in the community. This active diagnosis, combined with the potential ease of access to illegal substances and networks of drug users in the communities of release presents a conundrum for treatment providers. The movement towards combining substance abuse and psychiatric treatment through concurrent disorders initiatives addresses the findings of this study by providing a holistic approach to managing mental illness. Broadening the view of substance abuse and mental disorder to include regional variations in these problems will help to identify 'areas of need' for both mental health and addictions services and will help treatment providers to address changes within an individual's environment that can impact positively on their path to independent and healthy living.

7.2 Proposals for Policy Making

In addition to treatment implications, the results of this study are suggestive of directions for policy development for the forensic mental health system. By addressing the question of which types of environments are entered into by NCR accused persons,

we also must address the reasons for their selection of those particular communities. In this study, clusters of residences were evident around the areas of the forensic outpatient clinics: therefore, access to treatment services would presumably be increased for those living in close proximity to them. However, these clusters beg further examination in order to determine whether individuals are moving into areas that provide access to services or whether services are being placed in regions where the service users are most likely to be situated. Placement of treatment facilities in neighbourhoods that expose released clients to destabilizing features (such as those characterising socially disorganized communities) perpetuates the difficulty for released patients of avoiding the crime, violence, stress, and substance abuse that can be so damaging for reintegration. Hodgins (2000) suggested that immediate attention is needed to determine the influence of particular living environments on the risk of offending or violent behaviour with mentally disordered offenders. Her suggested field of concentration reflects the ongoing policy issues surrounding deinstitutionalization and the provision of sufficient community-based treatment models. Upon decentralizing treatment services into community clinics, a new need has developed to consider the interrelation between environmental and individual effects on human behaviour. Variables such as social networks and access to illegal substances were much more likely to be controlled in the environment of a centralized inpatient hospital. However, these same variables undoubtedly exert a much greater influence on accused persons in an outpatient setting. Therefore, development in the area of policy needs to reflect the external influences that bear influence on the successful placement of an NCR accused in a residential setting by considering the location service delivery.

Expanding on the placement of outpatient treatment facilities, Review Boards also have the opportunity to include geographic perspectives in their decisions when contemplating the release of an NCR accused. The findings of this study show that Review Boards in British Columbia are not regularly considering geographic features of a release location when determining whether to discharge an accused. Legal decisions such as *Winko* (1999) and *Orlowski* (1992) have focused the Review Board's concentration onto issues of risk and significant threat, but the measures of what constitutes a risk is still debatable. Individual risk factors such as presence of psychotic symptoms and expected treatment compliance were given great weight in the discharge orders of this sample, suggesting that these variables are critical in estimating an individual's risk to society. However, by including broader contextual issues in the assessment of risk, a fuller understanding of potential risk factors might be achieved.

Review Boards are already considering social support and living arrangements in the course of their decision-making, with these factors being discussed in over 80% of all cases in the sample. Board members are currently including these contextual variables in their assessment of risk, but there exists room for expansion. Risk assessment instruments that are being developed for this forensic psychiatric population have begun to emphasize community features as being potentially influential on a patient's risk. For example, the HCR-20 Violence Risk Management Companion Guide (Douglas, K.S., Webster, C.D., Hart, S.D., Eaves, D., & Ogloff, J.R.P., 2001) describes the importance of building stable environments (factor R2 in the risk assessment) as a means to reduce risk for both released and secured patients. They promote the identification of destabilizers and negative influences in the community, which may present an individual with stressful

situations or threatening events. By including such contextual variables as neighbourhood features, social housing, and interpersonal support networks, Review Boards and risk assessment professionals can better identify the antecedents of successful reintegration after forensic care.

In order to fully incorporate neighbourhood-level risk factors into Review Board considerations and release planning, it is necessary to understand the spatial patterns of forensic clients' residences following their release into the community. For this reason, I advocate the use of geographic modelling in forensic mental health policy planning and development. Spatial distributions and mental health geographies have existed since the pioneering study by Faris and Dunham (1939): however, traditional studies in the area of geography and health have focused on the prevalence of various mental disorders. Studies undertaken by the early social ecology theorists were concerned with the distribution of mental illnesses across urban centres, showing the most notable incidence of psychotic disorders occurred in those areas that were closest to city centres (Faris & Dunham, 1939; Owen et. al, 1941; Shaw & McKay, 1969; Traub & Little, 1994). These early studies explored how illnesses such as schizophrenia and hysteria were distributed across a city with increasing concentrations in the downtown core. While the presentation of mental illness distributions is useful to the understanding of the precipitating factors of psychiatric disorders, it is a limited use of what geographic models can provide for mental health planning. Unlike the findings of the early social ecology theorists, it is now recognized that the existence of neighbourhood concentrations of mental health consumers does not necessarily suggest a causal relationship between the community contextual influences and the onset of mental illness. Instead, geography can be used as a

tool to identify the areas to which clients return upon their release from hospital and to explore the positive and negative influences present in those communities. Of utmost importance to the study of these release distributions is the comprehension of released patients' movement patterns over time. Geographic and spatial models will progress our knowledge of what happens to patients after they leave inpatient treatment, especially after they reach the stage of fuller independence from their outpatient treatment team. In a commentary on the field of mental health geographies, Philo (2005) astutely comments:

Only once we realize the varying ways in which different neighbourhood environments are implicated in the changing mental health states of 'vulnerable' individuals, from inception through onset into possible recidivism, can we begin to infer what lies beneath the broad-brush spatial patterns of apparent incidence. Such an approach embraces the possibility that some places *do* become integral to the production of mental ill-health, but it also alerts us to the possibility of movements, of people's deteriorating mental health paralleling their 'drift' into different places perhaps some way distant from their original (family) homes. (p.587)

Therefore, early studies of psychiatric illness distributions should not be taken as representing the limit of what geographic perspectives can provide for mental health research. Instead, a renewed interest in neighbourhood influences and community disorganization can expand the applicability of geographic modelling for forensic health policy.

7.3 Considerations for Urban Planning

The results of this study rely heavily on a theoretical model that surrounding environmental factors influence individuals and their behaviour. Given this assertion, it follows that the findings of this thesis have implications for the field of urban planning, especially in relation to the distribution of land use in Vancouver and Surrey. Spatial

representations of the residential patterns of NCR accused persons in this sample showed a clear movement toward the areas of Mount Pleasant/Downtown Eastside in Vancouver and Whalley in Surrey, with patterns becoming more pronounced over time. Indeed, the findings also show that these geographic areas that are prone to exhibit elevated levels of poverty, unemployment, immigration, and rental accommodation as compared to their surrounding communities. In order to address the difficulties that will naturally arise regarding successful reintegration of forensic clients into these neighbourhoods, urban planning professionals should consider the possibility of integrated land use; that is, redistributing clustered areas of social services and social housing into other communities that have traditionally housed less of these services. Currently, an overwhelming proportion of mental health and addictions services are located in the very neighbourhoods outlined in this study that have features of social disorganization (e.g. Vancouver's Downtown Eastside). Decentralizing the location of these services by supporting zoning applications and rent incentives in other, more established, communities avoids the reinforcement of providing social services in a ghettoized or socially disorganized setting. By combining land use zoning for mental health services along side other commercial or health services, mental health treatment will be made more accessible in diverse urban settings.

Likewise, affordable housing for NCR accused persons leaving forensic custody was found in this study to be located in communities that exhibit features of a 'zone of transition'; where economic and social hardship has the risk of inhibiting residents from investing in the long-term well-being of the neighbourhood. By planning for supported mental health housing in communities that have demonstrated their commitment to a safe

and healthy neighbourhood, newly released patients will benefit from an environment that is less tumultuous and more suited to successful residential placement. This will require significant acceptance on the part of community residents, who will likely be apprehensive with the prospect of bring mental health and addictions services into their districts. However, if urban planners work together with mental health professionals in the assessment and development of new areas for community-based residential services, it is likely that many forensic clients can function and reintegrate successfully into these supportive environments.

7.4 Directions for Future Research

Results of this exploratory study show that there is much to be learned in the combined area of geography and forensic psychiatry. It is evident that environmental perspectives on mental health can provide a new and innovative outlook on the reintegration of released forensic patients into community settings, especially in urban settings. Studies involving the influence of social supports, community acceptance, structured housing, and neighbourhood violence will be instrumental to the field of forensic systems research, since these features can provide invaluable insight into the contextual influences that may interact with standard community treatment paradigms. Variables that are highlighted in the social disorganization literature will help to guide the direction of mental health geography research by focusing researchers' attention on the community features that are most influential on human behaviour. The findings of this study suggest that future research should expand and redirect the social ecological concepts into mental health research, with a particular focus on the socioeconomic features and social network potential of residential neighbourhoods. By including

environmental characteristics in future psychiatric research, a fuller impression of psychiatric, substance abusing, and criminal risk factors are considered.

The current study focussed on quantitative methodology only as a means of exploring the geographic influences on released NCR accused. A qualitative component to the study was originally intended; however, there were numerous unanticipated barriers that arose regarding the feasibility of qualitative research in this field. As can be seen in the methodology chapter, qualitative interviews were to be arranged through the Community Legal Assistance Society (CLAS) with individuals who had been absolutely discharged from forensic care. The interview was designed to uncover the issues that patients face when they receive a discharge from hospital into the community. Questions involved the discussion of patients' experiences with staying in touch with friends and family, choosing where to live, and the safety of their community. Initial attempts to arrange these interviews occurred in the form of a formal letter sent out by CLAS to their former absolutely discharged clients, requesting that they book an interview in exchanged for a small honorarium. CLAS was to identify and assess individuals who they thought could participate in a 30 minute interview, and upon the client's agreement, an interview would be arranged through the CLAS office. No responses were received to this letter. As an alternative avenue to accessing this population, CLAS representatives notified this researcher of any individuals who were appearing before the Review Board at a hearing where an absolute discharge disposition was likely. Patients had been made aware of the opportunity to participate in this study prior to their hearing and would agree to an interview later that day on the condition that they received an absolute discharge. Unfortunately, during the remaining time of this study, only one person received an

absolute discharge. An interview was conducted with this individual (see Appendix F for interview instrument), but obviously cannot be used for full research purposes. However, the themes that arose from this interview suggest that further attempts at qualitative research must be made. This interview revealed the importance of family connections to this patient:

I am very close to my family...I don't have, um the way I see it is that my family is pretty interesting and I really enjoy them as friends as well as family. I don't go outside my family to seek other friendships.

This individual also noted some interesting insights on her decision about where to live upon release from community. For her, living near a clinic did not factor into her plan whatsoever, whereas living away from her index offence appeared to be one of the most salient factors in choosing a community. In discussing the features of her community, this patient explained the type of surrounding neighbourhood she lives in:

Ya, um, that's not very good because there's, I'm sorry to say, but there's like prostitutes that work on [] but that's at night, I don't go out at night. I just stay in my apartment and sleep so it doesn't really bother me one way or another. But the area isn't great, it's not the best location, but I could find a lot worse elsewhere.

Also, in discussing experiences with violence or victimization, it appears that victimization within pre-trial and non-psychiatric correctional settings should be explored through qualitative analysis. This patient noted the stigma that being a forensic patient brings when staying in standard correctional facilities and comments that this led to other inmates singling her out as a target:

Ya well, they didn't particularly like that I was a quote un-quote an MDO, a mentally disturbed offender, so that part of it was also a factor. So it was a little bit uncomfortable but I had to deal with it.

As can be seen from the interview themes outlined above, qualitative research can be vital in understanding the experiences of released NCR accused persons both prior to and after their involvement with the forensic psychiatric system. Future qualitative explorations should bear in mind the difficulties that are present when attempting to gain interview subjects, as individuals who have finished their involvement with the forensic system may want nothing to do with it again. Playing into this reluctance may be the stigma felt when labelled as a mentally disordered offender, or may be reflective of a patient's desire to carefully monitor their candour for fear that it may reflect upon the Review Board's decision to release them. In any case, further qualitative research would undoubtedly enrich the field of mental health literature, especially when exploring community reintegration.

Qualitative methods should also be used to expand the scientific literature regarding Review Board decision-making. There is little to be found in published research that considers the types of factors that are relied upon by Review Boards and Tribunals when a decision is made to release or not release a patient. In one of the few articles published on decision-making, Wood (1999) suggests that there is an underlying tension between the three aspects represented at British Review Tribunals (as in Canadian Review Boards)—the legal, medical, and social work perspectives that are embodied in the Board's members. He discusses that decisions are made with each member focussing on their area of expertise as the most important variable for release. It is possible then that members will consider different information as being most important in their own decision-making. With a legal concentration on 'significant threat' and the multitude of psychological risk assessment instruments that are used to inform Review Board

members as to the potential threats posed by a patient, interviews with Review Boards can explore their reliance on these legal and psychological measures in their release decisions. As seen in this study, geographic factors only appear to be considered in release decisions if it is in reference to the issue of victim avoidance. Qualitative interviews will be able to better assess the inclusion of environmental characteristics and contextual factors in Review Boards' decisions than a content analysis on written decisions. These written decisions do not necessarily captured the finer details of discussions and considerations used in the releasing process and are not as enlightening to this area of research as direct interviews with Board members will be. For this reason, qualitative research with Review Boards can only improve our knowledge of the practical applications of risk assessments and will help in the determination of the potential importance of environmental influences.

Finally, more sophisticated quantitative research will permit further correlational and causal contextual variables to be identified in the successful reintegration of released NCR accused persons. The results of this study suggest a focus on individuals who frequently return to hospital, since their patterns of movement into social disorganized communities seems most pronounced. Future research should include regression models that compare the number of returns to hospital (and the reasons for these returns) with community socioeconomic variables in order to examine which community factors influence the revocation of conditional discharges. Regression techniques will permit for the exploration of correlations between community factors and mental health variables, while continuing to lend credence to the spatial mapping techniques used in this research. By continuing the study of mental health and community variables with higher-level

correlational techniques, future research can direct new forensic policy initiatives for the recognition and incorporation of environmental perspectives into patient release planning.

CHAPTER 8: CONCLUSIONS

The results of this thesis serve to highlight the ongoing difficulties associated with managing released NCR accused persons in the community. Deinstitutionalization and the transition towards a community-based treatment model have become common practice in general mental health services across Canada; with forensic psychiatric services developing a similar approach. However, the legal framework in place for releasing forensic patients promotes a substantial reliance on the element of 'risk', where an NCR accused person is eligible for conditional discharge if they do not present as a significant threat to the safety of others in society. While treatment needs will evidently form some portion of the assessment of an individual's risk, these needs are assumed to be able to be filled by outpatient mental health services once an individual is released. It is in regard that current models of community treatment are potentially limiting their success by not considering the spatial distribution of their service centres and service users.

Existing research in the area of forensic mental health has shown limited exploration of the importance of community-level variables. It is hoped that this study has added to the current literature by promoting an ongoing need to assess broader environmental influences on the reintegration of NCR accused persons who are leaving a custodial setting. The current forensic model in British Columbia has shown a great degree of understanding of the individual risk and treatment needs of NCR accused persons entering the system, as evidenced by the Review Board's reliance on these

variables in their release decision-making. The Board has yet to include much discussion of geographic considerations in their discharge decisions; and similarly, risk assessment instruments are just beginning to include contextual variables in their models (such as the HCR-20). In considering the findings of this study, forensic psychiatric service systems could benefit from a re-evaluation of the potential positive and negative consequences of releasing their patients into different communities.

In the same way, this study underscores the need to explore the relationship between the location of mental health and addictions treatment and the location of the client population using these services. The spatial analysis of patient movement after release for forensic care showed a clear clustering of residences in the area surrounding both the Surrey and Vancouver forensic clinics. This finding supports the need for an examination of the reasoning behind this clustering around treatment services—do people migrate closer to where they receive outpatient services, or do hospitals provide outpatient services in the areas where there are the most service users? In either case, the results of this research stress the potential benefits and unintentional consequences of providing forensic outpatient services in certain neighbourhoods.

While a neighbourhood-based theory may appear to be an unusual approach to the understanding of individual health and behaviour, it can inevitably bring forward a new and broad perspective to the field of forensic psychiatry. Environmental theories have not traditionally been applied in psychiatric literature, in part because of their development in and focus on topics related to Geography and Sociology. The applicability of researching trends in group behaviour and spatial analyses of such actions has been limited in the field of Forensic Psychiatry, in part due to the very small population base of forensic

patients. However, the outcome of this review demonstrates the value in resurrecting older theoretical concepts and applying them in new ways to the understanding of current problems. It appears that the combination of environmental criminological perspectives with forensic mental health provides a valuable lens through which to examine the release of NCR accused persons.

Overall, this thesis speaks to the importance of an integrated approach to forensic mental health services. This includes the need for the medical expertise of psychiatry, the clinical expertise of psychology, the social adjustment expertise of social work, the attentive care of nursing, legal and criminal expertise of criminology, and the spatial analysis expertise of geography. This is truly a field where a multidisciplinary approach is of greater value to research and treatment than the sum of its individual and competing parts. Just as each of these areas are important to the study of mental health and crime, so too should they be integrated into the solutions and treatment of mental disorder and crime.

APPENDICES

Appendix A: Conditional Discharge Orders

Primary Conditions:

- That he be subject to the general direction and supervision of the Director, Adult Forensic Psychiatric Services
- That he reside in such a place in the Province of British Columbia considered appropriate by the Director and not change his residence without prior approval of the director
- That as required by the Director, he attend and report to the AFP Outpatient Clinic nearest his place of residence, or at any other place, for purposes of assessment, counselling, assisting him with regard to any treatment, promoting his reintegration into society, or monitoring his compliance with this order
- That he return to and remain at the Forensic Psychiatric Institute where the Director is of the opinion the accused's mental condition requires assessment as he may be a danger to himself or others
- That he not acquire possess or use any firearm explosive or offensive weapon
- That he keep the peace and be of good behaviour
- That he present himself before the Review Board when required

Secondary Conditions:

- That he not consume alcohol or use hallucinogens
- That he not use any drugs except as approved by a medical practitioner
- That the Director may monitor his compliance with this order by testing for the use of alcohol, hallucinogens or unprescribed drugs where there are reasonable grounds to suspect that condition 6 or 7 of this order has been violated and the accused shall submit to such testing upon the demand of the Director

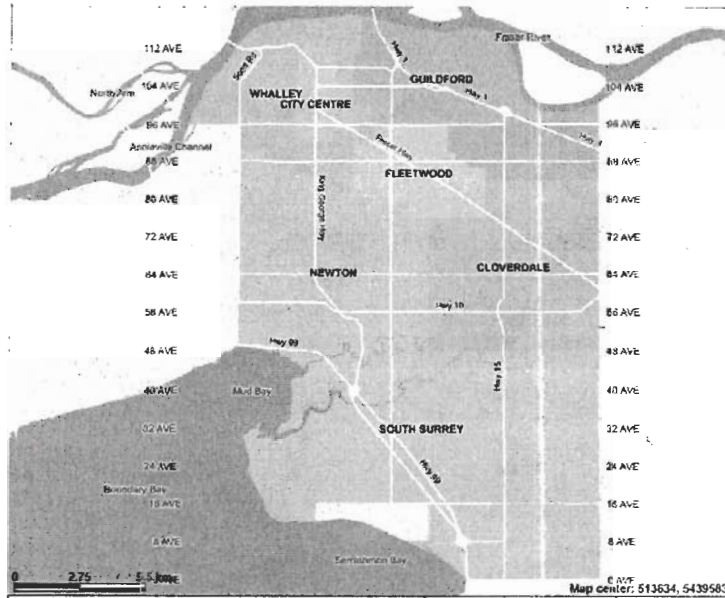
Tertiary Conditions:

- That for the accused's next hearing of the Review Board the Director provide as disposition information, a comprehensive assessment of the degree to which the accused poses a threat to public safety

- That he have no direct or indirect contact with _____ or any member of his or her family unless approved by the Director
- That at his discretion the Director may subject to reasonable terms and conditions permit the accused to travel to _____ depending on the accused's mental condition and having regard to the risk the accused poses to others at the time
- That he not go to _____ address
- That he not attend any private premises where alcohol is being served or commercial premises where alcohol is the primary commodity being sold
- That where she consults a medical practitioner other than one designated by the Director she authorize that practitioner to release information to the Director regarding the purpose of such consultation any medication prescribed by that practitioner and any other information relevant to proper supervision of the accused
- That subject to any order of the Provincial Court of British Columbia his contact with or access to _____ be at all times supervised by an adult considered responsible and approved by the Director
- That he not be in the company of children/females under _____ years of age unless accompanied by a responsible, informed adult
- That in accordance with s.672.58b of the Criminal Code the Review Board determines that the interests of justice require that counsel be assigned to represent the accused at his next hearing
- That he not have in his possession or view any child pornography
- That pursuant to s.672.551 of the Criminal Code and with the consent of the accused the Review Board considers it reasonable and necessary for the interest of the accused that the accused attend a drug and alcohol counselling and or relapse prevention program as approved by the Director and attendance by the accused at such a program is a condition of this disposition
- That the Director may designate the Forensic Psychiatric Institute as the accused's approved place of residence for all or part of the first 28 days following the date of this disposition order if the treatment team believes that it would be therapeutically desirable for the reunion with his wife and children to take place gradually over this period
- That the Director have this order translated into the Vietnamese language for the benefit of the accused

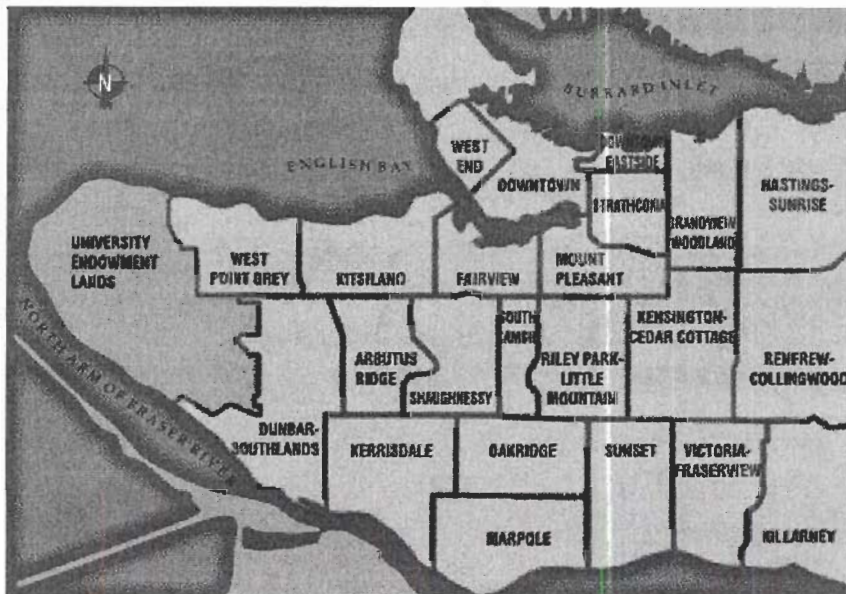
Appendix B: Community Boundaries for Lower Mainland Urban Areas

Surrey Community Boundaries



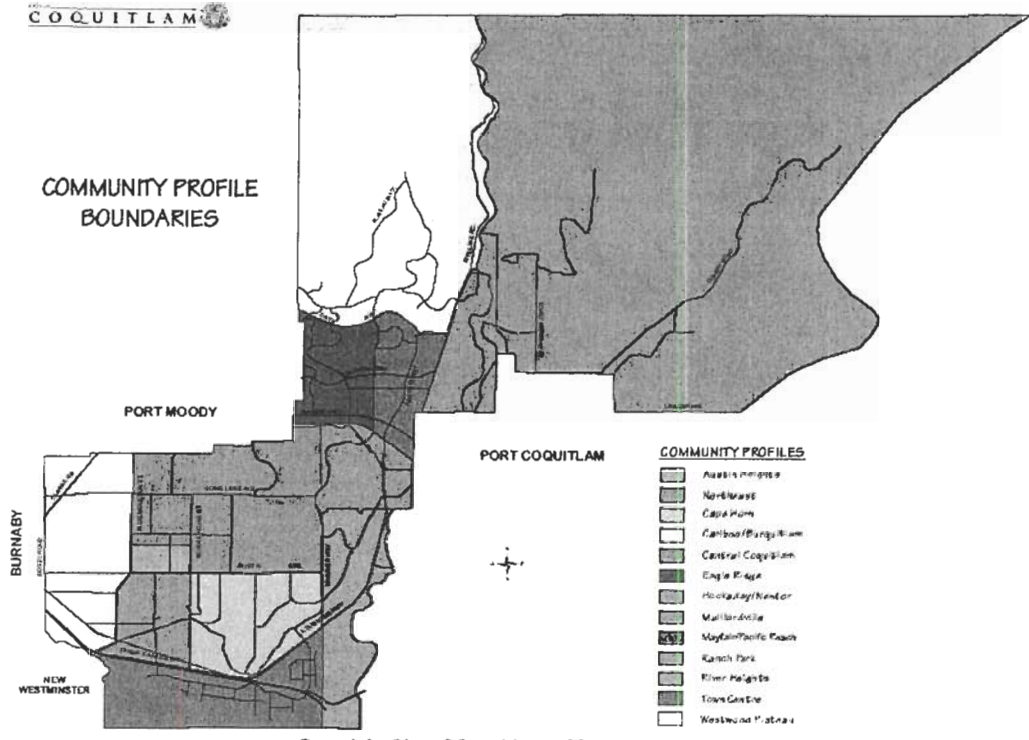
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Vancouver Community Boundaries



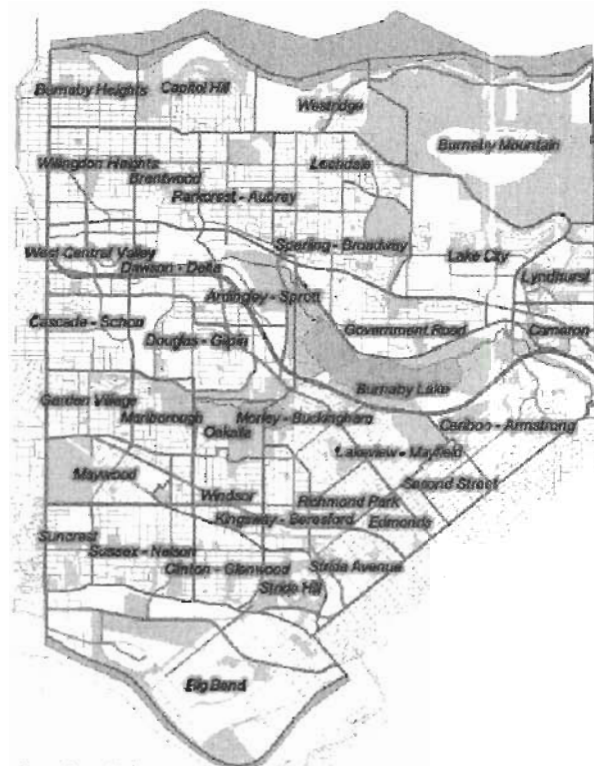
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Coquitlam Community Boundaries



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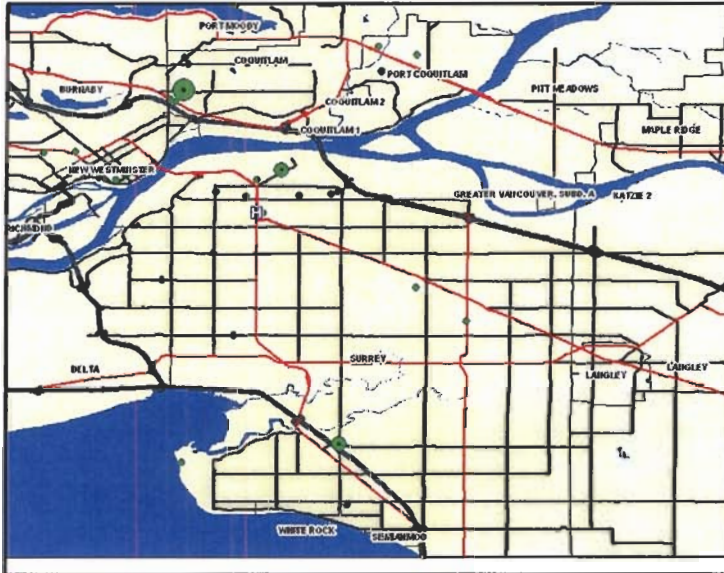
Burnaby Community Boundaries



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Appendix C: Zoomed Spatial Distributions for Conditionally Discharged NCR Accused

Addresses upon Conditional Discharge: Surrey Clinic



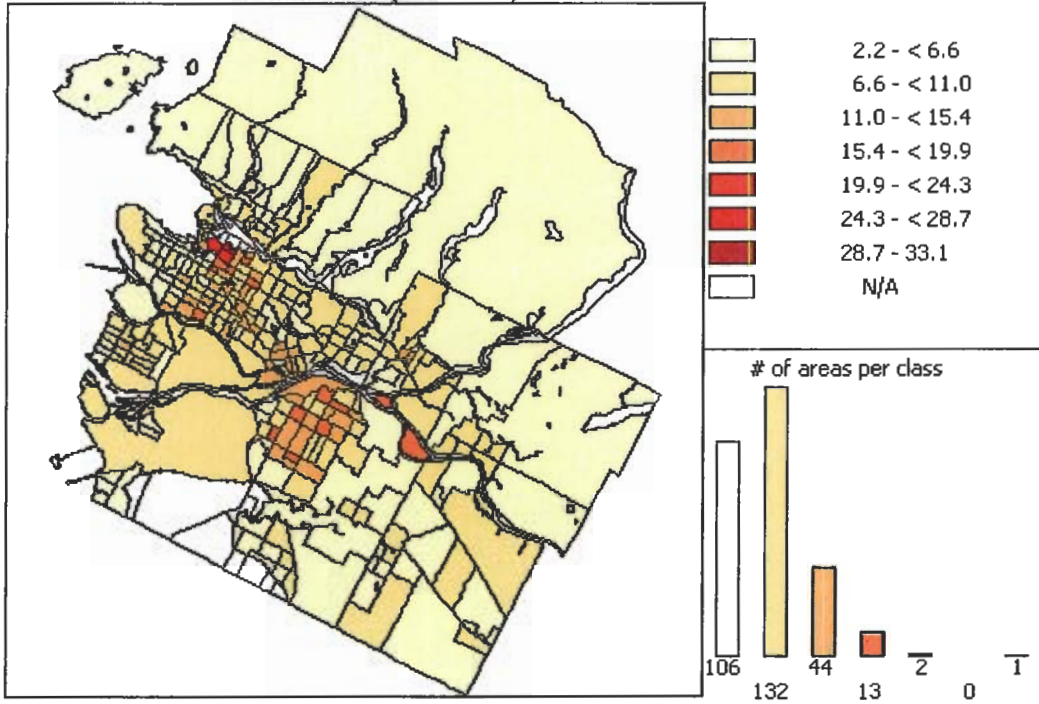
Addresses upon Conditional Discharge: Vancouver Clinic



Appendix D: Census Choropleth Maps

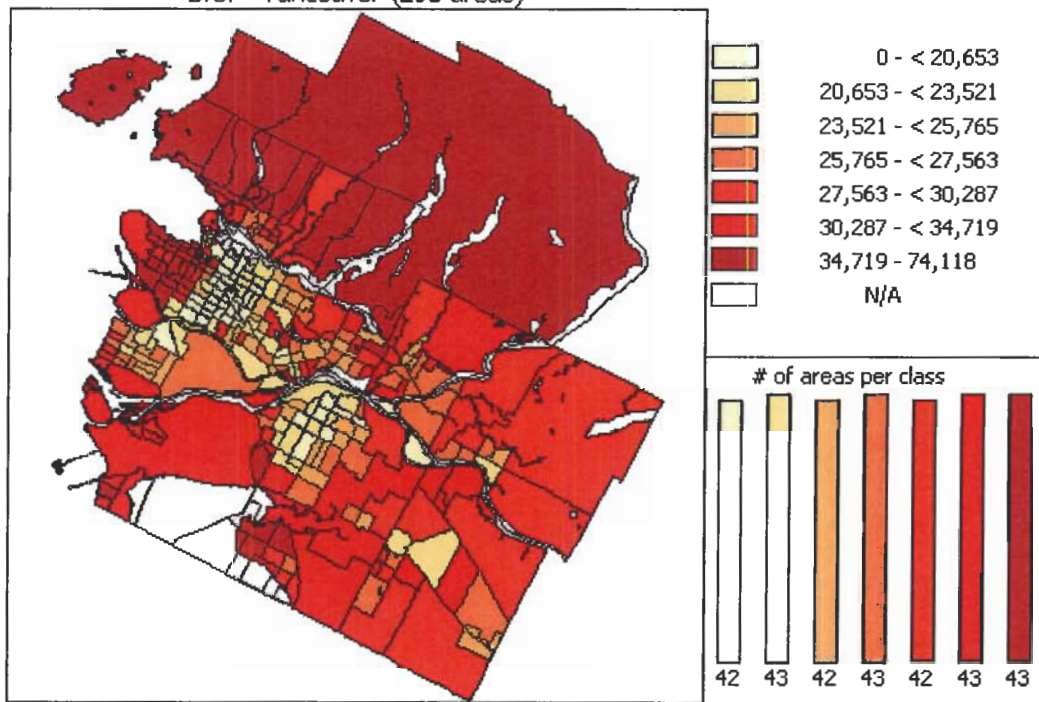
Unemployment Choropleth Map

Unemployment rate, population 15 years and over
B.C. - Vancouver (298 areas)



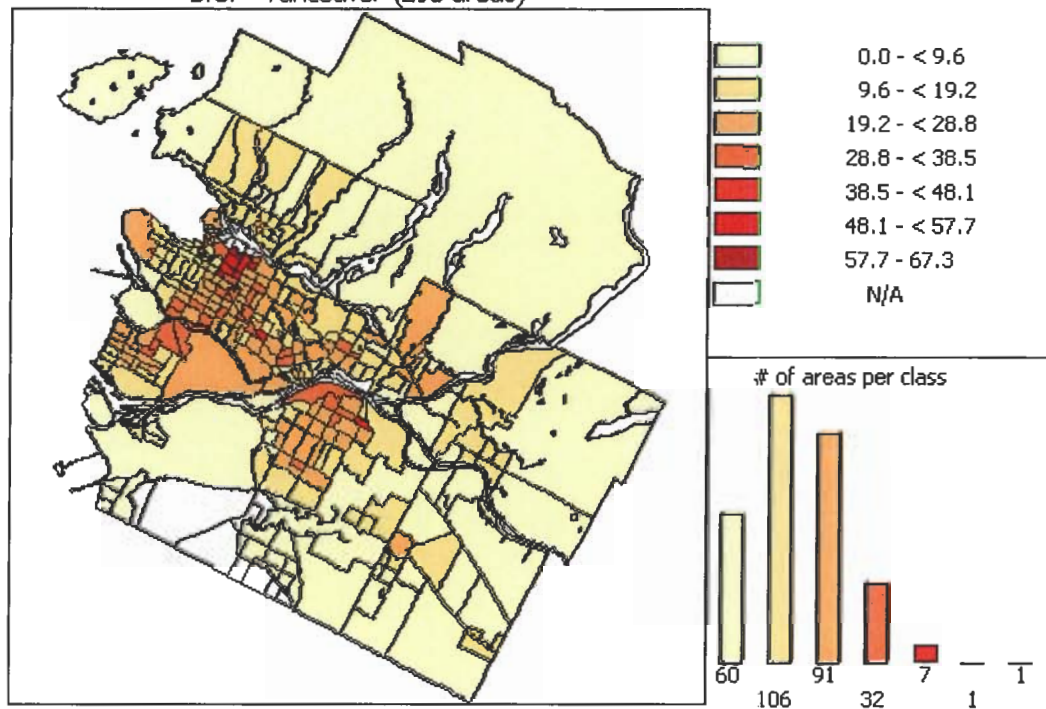
Income Chloropleth Map

Average income \$, population 15 years and over
B.C. - Vancouver (298 areas)



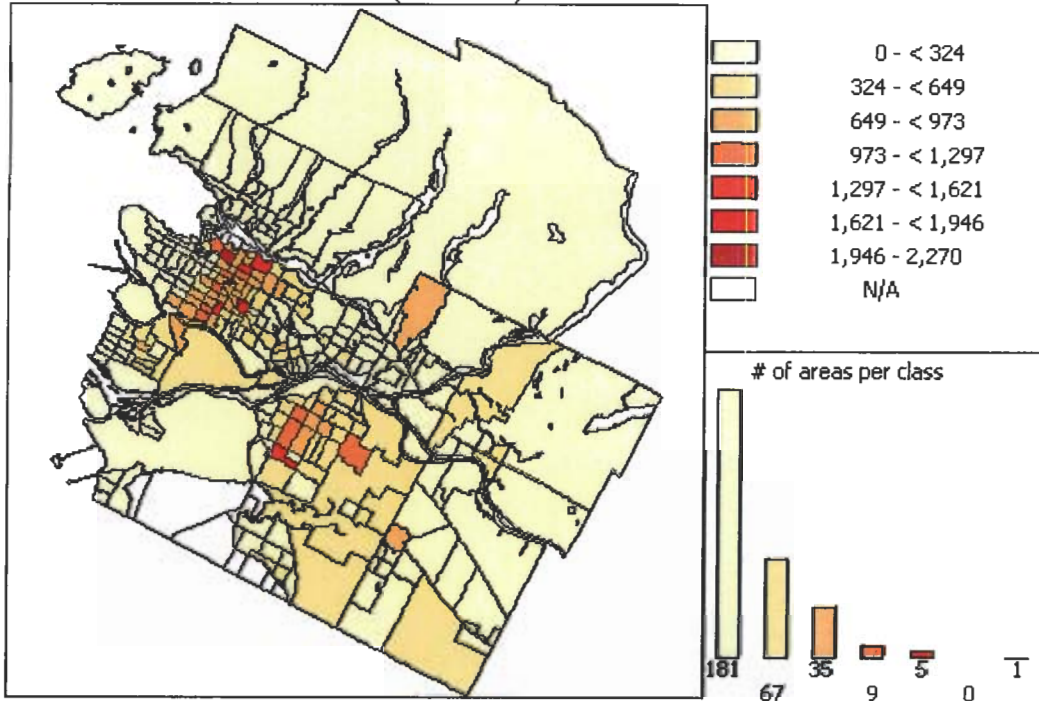
Poverty Chloropleth Map

Incidence of low income % - economic families
B.C. - Vancouver (298 areas)



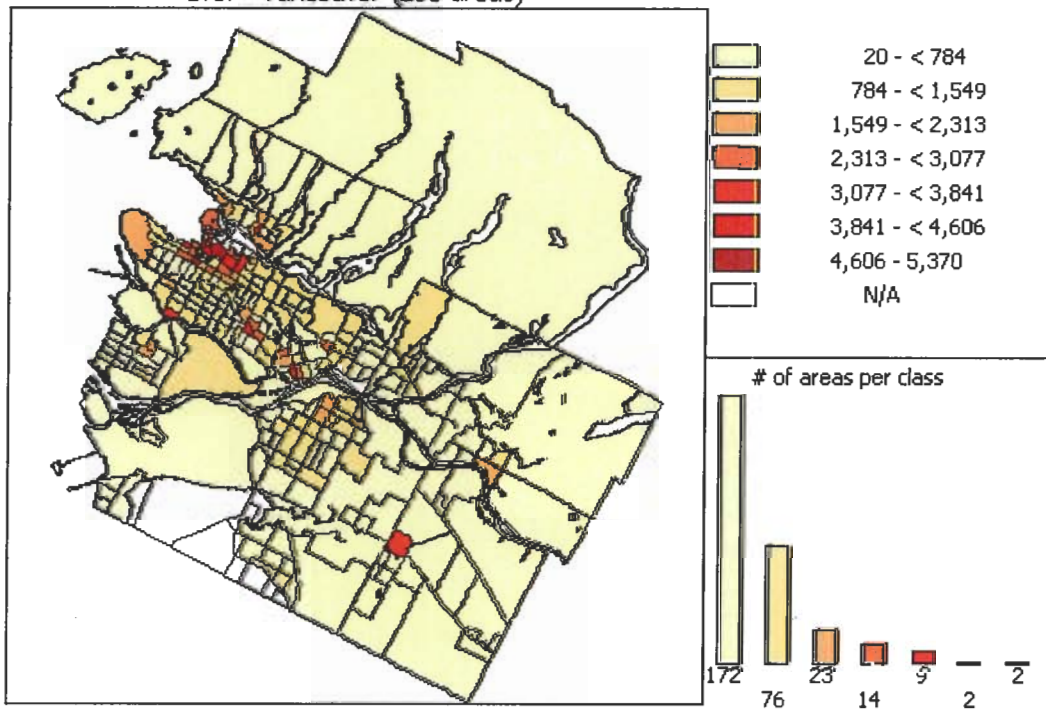
Education Choropleth Map

Less than grade 9, pop. 15 years and over by highest level of schooling
B.C. - Vancouver (298 areas)



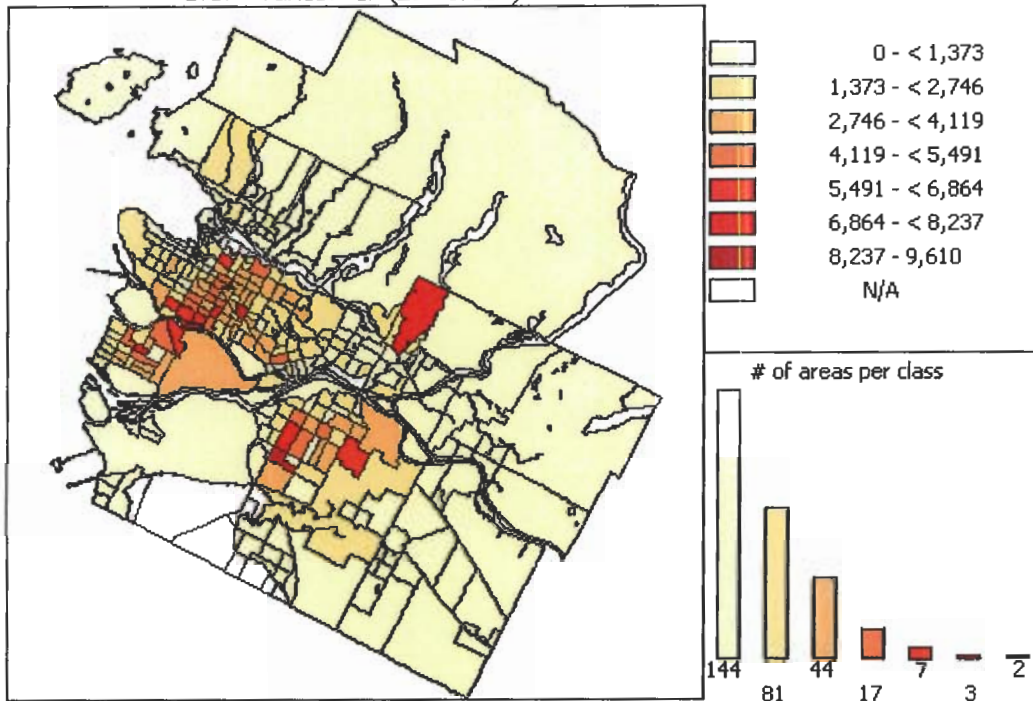
Rental Accommodation Choropleth Map

Rented, dwelling
B.C. - Vancouver (298 areas)

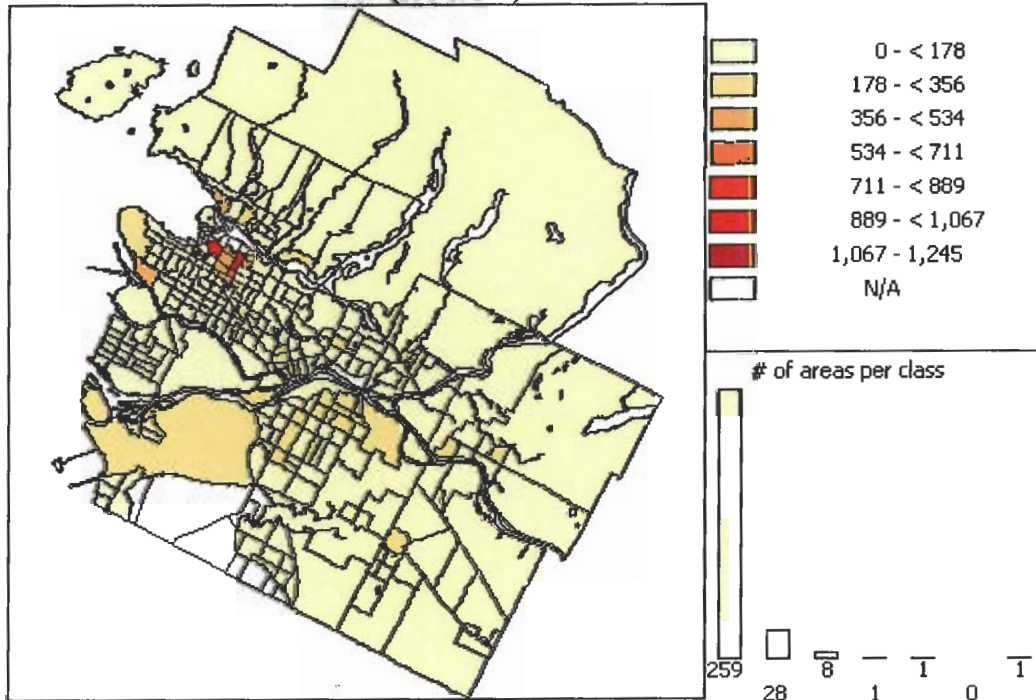


Ethnic Diversity Choropleth Maps

Total visible minority population
B.C. - Vancouver (298 areas)

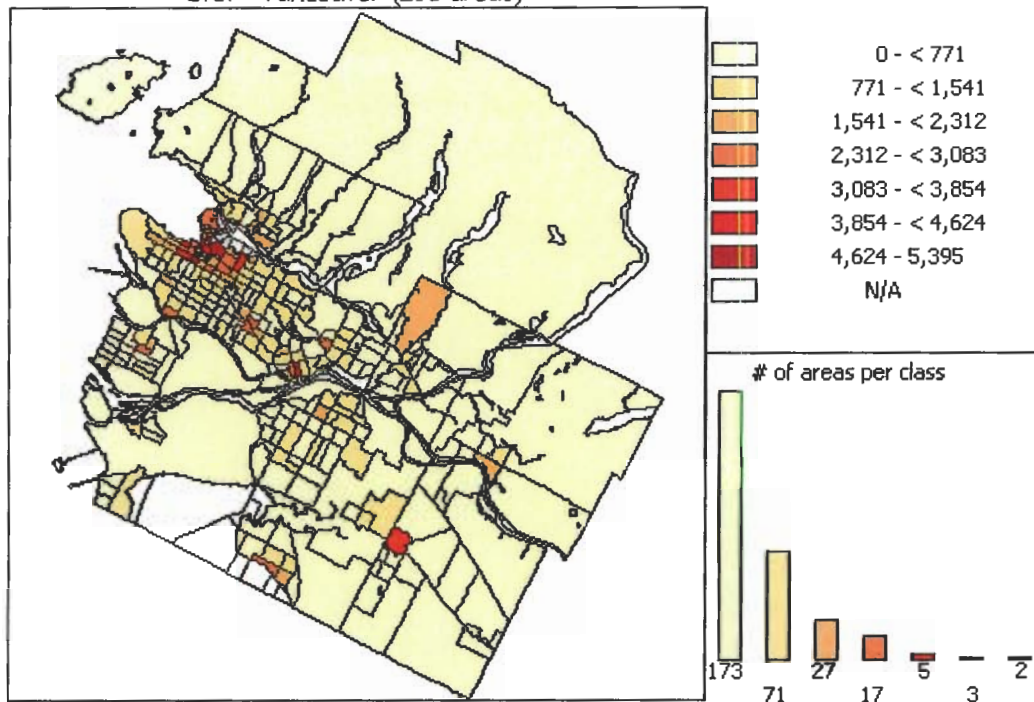


Total Aboriginal population
B.C. - Vancouver (298 areas)



Single/Unattached Occupancy Chloropleth Map

Total - Unattached individuals (20% sample data)
B.C. - Vancouver (298 areas)



Appendix E: Coding Sheets

**NCR ACCUSED RELEASE PATTERNS
PATIENT PROFILE FORM**

A. Identification

1. Study Number |_|_|_|
 2. Medical Record Number (mm) |_|_|_|_|_|_|
 3. Form Number |_|

B. Admission Information & Demographics

4. Date of Birth yy-mm-dd |_|_|_|_|_|_|
 5. Admission Date yy-mm-dd |_|_|_|_|_|_|
 6. Admission after NCRMD: |_|
 1=FPH 2=Vancouver Clinic 3=Surrey Clinic
 7. Sex |_|
 1=Male 2=Female 3=Unknown
 8. Marital Status |_|_|
 1=Single 2=Married 3=Widowed 4=Divorced 5=Separated 6=Common-law 98=U/k
 9. Education |_|_|
 1=None 2=Elementary 3=Jr. High 4=Sr. High 5=Post sec some 6=Post sec complete
 7=Univ some 8=Univ complete 9=Tech/trade 10=Vocational 98=U/k 99=Other
 10. Employment Status |_|_|
 1=Self 2=Unemployed 3=Employed F/T 4=Employed P/T 5=Seasonal 6=Military
 7=Retired 8=Homemaker 9=Student 98=U/k 99=Other
 11. Ethnic Group |_|_|
 1=Caucasian 2=Aboriginal 3=Asian 4=East Indian 5=African 98=U/k 99=Other
 12. Financial Support at Admission |_|_|
 1=No income 2=Income Assistance 3=Pension 4=Employed P/T 5=Employed F/T
 6=supported by family 7=supported by friends 8=Savings 9=UIC 98=U/k 99=Other
 13. Home Address at Admission:

Street address	City, Province	Postal Code
----------------	----------------	-------------

14. Housing Type |_|_|
 1=Transient/nfa 2=Alone at hotel 3=Alone at regular address 4=wife/common-law
 5=With immediate family 6=With relatives 7=Boarding/group home 8=Hospital
 9=With friends/roommates 98=U/k 99=Other
 15. Living With |_|_|
 1=Alone 2=Spouse/Com-law 3=Parents 4=Friends 5=Other relatives 98=U/k 99=Other

**NCR ACCUSED RELEASE PATTERNS
MENTAL HEALTH AND LEGAL FORM**

<u>A. Identification</u>			
1. Study Number			_ _ _
2. Form Number			2
<u>B. Mental Health</u>			
3. Previous contact with Mental Health services?	1=Yes 2=No 3=U/k		_
4. Inpatient admissions – Civil?	1=Yes 2=No 3=Unknown		_
5. Inpatient admissions – Forensic?	1=Yes 2=No 3=Unknown		_
6. Civilly committed?	1=Yes 2=No 3=Unknown		_
7. Diagnosis at Discharge			
Axis	_____		_ _ _
Axis	_____		_ _ _
Axis	_____		_ _ _
8. Psychopathic	1=Yes 2=No 3=U/k		_
<u>C. Legal Status</u>			
9. Most serious charges (NCRMD offences)			
	Charge	Code	Criminal Code section
1.	_____	_ _ _	_ _ _ · _ _ _
2.	_____	_ _ _	_ _ _ · _ _ _
3.	_____	_ _ _	_ _ _ · _ _ _
10. Under the influence of drugs or alcohol	1=Yes 2=No 3=Unknown		_
11. Relation to victim(s)			
	1=Stranger 2=Police Officer 3=Friend/Acquaintance 4=Relative 5=Other 6=U/k		_ _ _
12. Total number of victims (personal/violent charges only)	Code up to 6 victims 7=7 or more 9=Unknown		_
13. Type of Weapon(s) used			
	1=Knife 2=Gun 3=Hands 4=Blunt Object 5=Other 6=U/k		_ _ _

**NCR ACCUSED RELEASE PATTERNS
CONDITIONAL DISCHARGE & REVIEW BOARD FORM**

A. Identification

- | | |
|-----------------|---------|
| 1. Study Number | _ _ _ _ |
| 2. Form Number | 3 |

B. Conditional Discharge

- | | |
|---|-----|
| 3. Number of reviews by Review Board prior to Conditional Discharge | _ _ |
|---|-----|

- | | |
|--|---------------------------|
| 4. Date of Review Board Decision – Conditional Discharge | yy-mm-dd _ _ _ _ _ _ _ _ |
|--|---------------------------|

- | | | |
|---|----------------------|-----|
| 5. FPSC Clinic involved in patient care | 1=Vancouver 2=Surrey | _ _ |
|---|----------------------|-----|

6. Conditions (photocopy and attach)

- | | |
|-----------|-----|
| 1. _____ | _ _ |
| 2. _____ | _ _ |
| 3. _____ | _ _ |
| 4. _____ | _ _ |
| 5. _____ | _ _ |
| 6. _____ | _ _ |
| 7. _____ | _ _ |
| 8. _____ | _ _ |
| 9. _____ | _ _ |
| 10. _____ | _ _ |
| 11. _____ | _ _ |
| 12. _____ | _ _ |
| 13. _____ | _ _ |

7. Review Board Reasons for Judgment – Is there discussion of the following issues?:

- | | | |
|-----------------------------------|------------|-----|
| 1. Threat to public safety | 1=Yes 2=No | _ _ |
| 2. Threat to self | 1=Yes 2=No | _ _ |
| 3. Presence of psychotic symptoms | 1=Yes 2=No | _ _ |
| 4. Expected treatment compliance | 1=Yes 2=No | _ _ |
| 5. Insight into illness | 1=Yes 2=No | _ _ |
| 6. Substance Abuse | 1=Yes 2=No | _ _ |
| 7. Geographic location of release | 1=Yes 2=No | _ _ |
| 8. Social support upon release | 1=Yes 2=No | _ _ |
| 9. Living arrangements | 1=Yes 2=No | _ _ |
| 10. Proximity to treatment centre | 1=Yes 2=No | _ _ |

**NCR ACCUSED RELEASE PATTERNS
GEOGRAPHICAL INFO & RETURNS TO CARE**

<u>A. Identification</u>			
1. Study Number			_ _ _
2. Form Number			4
<u>B. Geographical Information</u>			
3. Home Address at Admission:			
Street address	City, Province	Postal Code	
4. Home Address at Discharge:			
Street address	City, Province	Postal Code	
5. Subsequent address change:			
1.			_ _ _ _
Street address	City, Province	Postal Code	Year
2.			_ _ _ _
Street address	City, Province	Postal Code	Year
3.			_ _ _ _
Street address	City, Province	Postal Code	Year
6. Date of return to psychiatric care		yy-mm-dd	_ _ _ _
7. Date of conditional discharge		yy-mm-dd	_ _ _ _
8. Reason for return	1=RB 2=Court 3=Other		_ _
9. Substance use involved?	1=Alcohol 2=Drugs 3=None 4=Unknown		_
10. Violence involved?	1=Yes 2=No		_ _
6. Date of return to psychiatric care		yy-mm-dd	_ _ _ _
7. Date of conditional discharge		yy-mm-dd	_ _ _ _
8. Reason for return	1=RB 2=Court 3=Other		_ _
9. Substance use involved?	1=Alcohol 2=Drugs 3=None 4=Unknown		_
10. Violence involved?	1=Yes 2=No		_ _

Appendix F: Interview Instrument

Introductions of researcher, along with explanation of research project. Research question: I am looking at the life experiences of people who have been absolutely discharged from forensic care. The types of communities they live in, their experiences with violence and substance use, and how they view themselves. This research will not directly influence you, meaning I will not talk to any agency or your CLAS representative about what you tell me unless the law requires it. Participants will receive a consent form at this point to read and sign.

1. When did you first get involved with mental health services?
2. When were you receiving treatment at the Forensic Psychiatric Hospital? How long were you there for?
3. Do you think you are close to your family or have good friends? How often do you see them?
4. Why do you think the Review Board released you when they did? What factors in your life do you feel they looked at?
5. When you were released, how did you choose where to live? Did you want to live close to your doctor or clinic?
6. When you were released, where did you want to live? Where did your lawyer recommend that you go? Did your lawyer tell the Review Board about your choice? Was the place you wanted to go, the same place you ended up at?
7. What is your life like since you were released? For example: living conditions, family, schooling, or work?

8. Since being released, has substance use (drugs, alcohol, etc.) been an issue in your life or your community?
9. Is there any point before, during, or after your hospital stay when you had problems controlling your emotions? Do you think people single you out to get beat up or attacked?
10. Has your involvement with the mental health sector affected your identity, or how you view yourself?
11. I am finished asking specific questions, but is there anything else that you would like to add? Anything you feel is important or that you want to discuss with me and the other readers of this project?

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