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MAD OR BAD?

WOMEN AND THE FORENSIC PSYCHIATRIC PROCESS

by

Karen A. Ryan

B.A., Simon Fraser University, 1987

THESIS SUBMITTED IN PARTIAL FULFILLMENT OF

THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF ARTS

in the School

of

Criminology

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Mad or Bad? Women and the Forensic Psychiatric Process

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ABSTRACT

The role of the forensic psychiatric system in the social control of mentally disordered female offenders is explored through the comparison of the forensic processing of female and male subjects admitted to the Forensic Psychiatric Institute during a nine year period. Statistical comparisons of the social, psychiatric and criminal characteristics, as well as the forensic assessment outcomes, of females and males remanded for the assessment of fitness to stand trial, are supplemented by several brief case histories and excerpts from forensic records. Results suggest that the forensic psychiatric system operates as a point of diversion for female subjects from the authority of the criminal justice system into the authority of the mental health system. In addition, the forensic psychiatric system appears to act as an adjunct to the corrections system in the management of mentally disordered female offenders. These results, it is argued, reflect the influence of ideologically based conceptions of female deviance, "madness and badness", and the corollary preference for the use of less formal methods in the control of such deviance.

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CHAPTER 1

INTRODUCTION

The control of individual deviance may take a variety of forms, ranging from the informal control exerted by families and peer groups to the formal controls mandated by law and society. When informal controls fail to gain compliance, highly specialized processes of formal control may be brought to bear. One such process arises within the context of the criminal justice system as the indirect result of legislation designed to prevent the trial of those accused persons who are unfit or incompetent to stand trial and to prevent the conviction of those accused persons whose criminal responsibility is vitiated on account of insanity. The court's concurrent power to seek medical advice on these issues has given rise to legally mandated agencies specializing in forensic psychiatry which may be called upon by the court to assess the accused and provide information and recommendations in regards to a number of issues surrounding the pre-trial release, trial, and sentencing of an accused person believed to be mentally ill. The forensic psychiatric system may also be responsible for the treatment and containment of those accused persons who are found by the court to be unfit to stand trial or not guilty by reason of insanity. In addition, actors within the forensic psychiatric system are in a position to expedite the transfer of individuals from the authority of the criminal justice system to the authority of the mental health system

and thus the forensic psychiatric system represents a unique point of interface between these two pillars of formal social control.

The Governing Legislation

An individual caught up in the criminal process may also become enmeshed in the forensic psychiatric process via a variety of legislative provisions which authorize the forensic psychiatric system's role within the criminal justice system and which are applicable to all stages of the criminal process.[1] These provisions will be summarized in three parts.

First, there are several provisions in the *Criminal Code* (R.S.C. 1970, c.C-34) which allow for court-ordered psychiatric observation. Section 465(1)c allows the court to direct that the accused attend or be remanded in custody, for a period of up to sixty days as provided for in Section 465(2), for observation where there is reason to believe that "the accused may be mentally ill" or "the balance of the mind of the accused may be disturbed, where the accused is a female person charged with an offence arising out of the death of her newly born child". Sections 608.2(1) and (2) and 738(5) and (6) similarly provide for the court-ordered psychiatric observation of persons appearing before the appeal court and the summary conviction court

[1]Note that the *Criminal Code* provisions relating to mentally disordered offenders have been revised. The legislation summarized here relates to the provisions in effect at the time the subjects of this study were processed.

respectively. Section 543(1) governs the judicial procedure to be followed where "there is sufficient reason to doubt that the accused is, on account of insanity, capable of conducting his defence" and in subsection (2) provides, in language similar to 465(1), for the psychiatric assessment of such persons.

Second, individuals charged with a criminal offence may find themselves within the authority of the forensic psychiatric system as a result of a finding of 'unfitness' or 'not guilty by reason of insanity' (NGRI). Section 543(6) provides that "where the verdict is that the accused is unfit on account of insanity to stand his trial, the court, judge or magistrate shall order that the accused be kept in custody until the pleasure of the lieutenant governor of the province is known ...". The result of a verdict that the accused is NGRI under the provisions of s. 16 is similar to that produced by a finding of unfitness. According to s. 542(2) of the *Code*: "Where the accused is found to have been insane at the time the offence was committed, the court, judge or magistrate before whom the trial is held shall order that he be kept in strict custody in the place and in the manner that the court, judge or magistrate directs, until the pleasure of the lieutenant governor of the province is known." Regarding the options that are open to the lieutenant governor, s. 545 of the *Code* provides in part that where an accused is found to be insane, the lieutenant governor of the province may make an

order "(a) for the safe custody of the accused in a place and manner directed by him, or (b) if in his opinion it would be in the best interest of the accused and not contrary to the interest of the public, for the discharge of the accused either absolutely or subject to such conditions as he prescribes."

Finally, offenders serving sentences in provincial prisons may be transferred to "places of safe-keeping" by the lieutenant governor under the authority of s. 546(1) of the *Code*. In addition, there are provisions in provincial mental health and correctional legislation that allow for the transfer of prisoners to psychiatric institutions. Equivalent legislation pertaining to the transfer of mentally disordered persons under sentence in federal penitentiaries is to be found in s. 19 of the *Penitentiary Act* (R.S.C. 1970, c.P-6).

An accused person's first encounter with the forensic psychiatric system is commonly in the form of a fitness assessment. As legal doubt concerning the fitness of the accused to stand trial may signal the entrance of an accused person into the forensic psychiatric system, some of the substantive and procedural issues surrounding the use of s. 543 will be reviewed in order to give the reader a sense of the degree of discretion which may be exercised by court actors in their dealings with mentally disordered offenders.

Each of the *Criminal Code* provisions allowing for the court-ordered remand of accused persons rely upon the

undefined criteria of "mental illness" or "disturbed balance of mind" in the case of a female charged with infanticide. Whether one of these criteria has been met is left to the court's discretion. With respect to s. 543, the court's discretion is further relied upon in determining the issue of fitness to stand trial, as the *Criminal Code* fails to address the question of the threshold at which a person may be considered "capable of conducting his defence".[2]

In addition to these substantive issues, a number of procedural issues are also involved in the determination of fitness to stand trial. First, the *Criminal Code* is silent in regards to who may raise the issue of the fitness of the accused. In practice, the issue may be raised by either the defence or the prosecution or by the court itself on its own initiative (Verdun-Jones, 1981). Lindsay (1977) suggests that while the purpose of the fitness rule is to protect the accused from the unfairness that might result from trying an insane person, in practice, the fitness issue is often raised solely on account of the strategic advantage that might accrue to the party raising the issue.[3] The strategic importance in raising the issue of the accused's fitness stems in part from the consequences of a judicial finding of unfitness. For example, because of the inability of the

[2]Lindsay (1977) provides a number of examples taken from several jurisdictions to illustrate this point.

[3]Thomas Szasz in Law, Liberty and Psychiatry (1963) argues that "[t]he assertion that a defendant is mentally ill is *always* a strategic ploy." (pp. 30-36)

accused found unfit to raise a defence to the substantive charge, it is usually more advantageous to the prosecution than to the defence to raise the issue of fitness. The prosecution may raise the issue in cases where it would normally wish to raise the defence of insanity but where the insanity of the accused does not come within the scope of s. 16. The prosecution also has the opportunity to raise the issue where it feels that its case on the merits is vulnerable to attack by evidence introduced by the defence. In addition, because a finding of unfitness may result in an indeterminate custodial order, by raising the fitness issue the prosecution may be able to avoid the more stringent civil commitment procedures and still effectively confine persons whom it feels are dangerous and ought not to be free (Lindsay, 1977; Verdun-Jones, 1981).

Further procedural issues arise with respect to the legal purpose or purposes which court-ordered remands for psychiatric observation are to serve. Again the *Criminal Code* provides no help in this area. In practice, the psychiatric examination may serve a number of purposes, including: to provide recommendations regarding the accused's fitness to stand trial; to provide evidence upon which a defence of insanity may be raised; to provide the court with information that may be relevant to the issue of sentencing; to provide information that will assist in determining the advisability of commencing procedures for the civil commitment of the accused (Lindsay, 1977).

Psychiatrists often report on all four of these issues, but with respect to the issue of fitness alone, the remand for observation serves two specific functions. First, the judge may remand the accused for observation in order to assist the court in determining the threshold question of whether or not to try the issue of fitness. Second, if the court has already decided to exercise its discretion to hold a full hearing, it will usually remand the accused for observation for the purpose of obtaining psychiatric evidence for the trial of the issue itself. In practice, however, the remand may serve other purposes not articulated in, and perhaps not sanctioned by, the *Criminal Code*. First, psychiatrists, cognizant of the consequences of a judicial determination of unfitness, may use the remand period not only to diagnose the accused and assess his fitness to stand trial, but also to attempt to educate him in the procedures of the court-room, the meaning of the oath, the substance and legal significance of the offence for which he is standing trial, the meaning of a plea of guilty or not guilty, and the consequences of conviction, in order to 'make' him fit for the purposes of trial (Lindsay, 1977). Second, the circumstances of a forensic remand, including the custody of the accused, lengthy assessment and almost constant observation, as well as the availability of authorized mental health professionals, may be used to divert the individual out of the authority of the criminal justice system and into the authority of the provincial

mental health system under the provisions for civil commitment within the BC *Mental Health Act* (Verdun-Jones, 1981).

The legal issues surrounding the role of forensic psychiatry in the implementation of the formal controls of both criminal and mental health legislation are complex. Clearly, however, this system performs an important social control function in regards to those individuals whose deviance is both "mad" and "bad". The review of some of the substantive and procedural issues surrounding the use of s. 543 indicates that both court actors and psychiatrists, as well as the police (Menzies, 1987), may exercise a considerable amount of discretion in their dealings with accused persons whose mental state has been questioned. These discretionary decisions are, of course, based upon a variety of factors, both legal and extra-legal. It will be argued that gender, while certainly not the sole defining characteristic of an accused, is nevertheless an essential characteristic which, along with demarcations such as social status and race, is inevitably a factor in forensic decision making. Ideologically-based conceptions of female deviance, both criminality and madness, influence the forms of control deemed preferable in the management of such deviance. In the formation of this argument, some attention will first be given to the unique ways in which female deviance is defined and controlled in Western society.

Definition and Control of Female Deviance

In a society in which the roles of the sexes are deeply entrenched, it is not surprising that those women whose behaviors or lifestyles departed from their prescribed role have historically been considered deviant. The social controls which may be exerted on women can be formal or informal, external or internal, subtle or overtly coercive, but as Carol Smart (1978) argues, all are directed towards correcting women who stray from the prescribed roles of their times. The primary sources of such control are informal and of low visibility; they

> rest within, or arise from prevailing material conditions, cultural values, customs and social practices, such as the differential socialisation of male and female children within the family, schooling, forms of speech and language, media propagated stereotypes and numerous other seemingly innocuous social processes. (Smart, 1978, pp. 1-2)

Patterns of informal control involving women are often established and perpetuated within the private sphere of the family. As a child, a female may frequently be the object of informal controls, and then, as an adult, a woman may frequently be the instrument of informal controls in the childcare process (Hagan, Simpson and Gillis, 1979). In the absence of the control of family bonds, other systems of informal social control may arise.

Ephraim Mizruchi (1983) documents the rise and fall of one such system of control which arose during the thirteenth century as a result of a combination of the religious fervor of the times and a surplus of unmarried women. The growth

of armies and religious orders had diverted substantial numbers of men from matrimony and domestic life. This situation created equal numbers of unintegrated women.

The alternatives open to women during this period appear to have been limited: "A woman could choose marriage, if she were also chosen; independence, thus risking becoming in the eyes of the community a "loose woman"; or she could select some type of religious life" (p. 49). Thus a great many women become potential recruits for religious movements. The Beguines were one such movement which helped to integrate women, especially middle and lower class women, who could not be absorbed by nunneries. "Providing physical and social security, convenience, and opportunity for religious devotion, the Beguinage simultaneously functioned as an organizer of unattached women, both unmarried and widowed, and thus provided control over their daily lives" (p. 56). Therefore, although the Beguine pattern was religious in form, its functions were social and its appearance in the thirteenth century is directly related to the absence of informal familial control over large numbers of women.

The importance of family-enforced sex roles in the social control of women is also reflected in more formal types of female social control. The women's reformatory movement, which began about 1870, was dedicated to rescuing wayward young females and rehabilitating them through a programme of domestic, educational and moral training. The

ideal reformatory was to be located in the country, away from the vices of the city, and was to consist of clusters of cottages, each of which was to operate as a family unit, under the guidance of an older woman.[4]

The Western House of Refuge which operated at Albion, New York, from 1894 to 1931 was the first institution to realize all aspects of the idealized model of the women's reformatory. Nicole Rafter (1983) examines the role of this institution in the formalization and intensification of controls over women who refused to conform to certain standards of female propriety and argues,

> With establishment of this reformatory, New York extended the power of state control over a population of young, working-class women guilty mainly of 'offences' such as promiscuity, vagrancy and saloon-visiting. It created a new arm of the criminal justice system with authority to incarcerate such women for a period of years, during which the reformatory tried to retrain them to become chaste, proper and domestic. (pp. 288-289)

No comparable intensification of punishment occurred in the case of men sent to state prison. If arrested at all for the petty offences that led women to reformatories, men were fined or sentenced to short terms in gaol, just as women had been before reformatories were established (Rafter, 1983). Thus, the founding of institutions like Albion legitimated the double standard. Men simply were not

---

[4]Interestingly, early conceptions of the mental asylum, as described by Rothman (1971), also emphasized the need to isolate the patient, recreate the bonds of the family, and promote stability through regimentation and routine.

sentenced to state prisons for promiscuity and saloon-visiting.

Rafter (1983) reports that a review of Albion's official reports, prisoner registries and inmate case files indicate

> that the institution served two primary functions: sexual control and vocational control. It attempted the first, control of inmates' sexuality, by training 'loose' young women to accept middle-class standards of propriety, especially that which dictated chastity until marriage and fidelity thereafter. It tried to achieve the second, control of inmates' work lives, by training charges in home-making, a competency they were to utilize either as dutiful daughters or wives within their own families or as servants in the homes of others. (p. 291)

The conception of a woman's natural or 'rightful' place is clear. It is within the private sphere of the home, dependent, obedient and virtuous. Women who stray from this prescribed gender role, which effectively places them within the informal controls of the family, are deviant and require retraining.

Conceptions of Female Criminality

The work of Carol Smart (1977) indicates that the perception of female criminal deviance and its cure are still based upon a sexist ideology; sexist because it "attributes to one sex socially undesirable characteristics which are assumed to be intrinsic or 'natural' characteristics of that sex" (p. 91). This ideology, which underlies most criminological and sociological theories of female criminality, is based upon the uncritical acceptance of assumptions concerning the relationship between bio- and

psycho- genetic forces and female social characteristics and behavior (Chunn and Menzies, 1990; Heidenshohn, 1985; Morris & Gelsthorpe, 1981; Smart 1976).

Historically, Cesare Lombroso represents one of the earliest and most influential proponents of the biological or constitutional approach to crime causation, but while Lombrosian explanations of male criminality have generally been repudiated, the ideological content of his work on female criminality persists in contemporary explanations. Lombroso (1895) argued that the natural characteristics of women made them less inclined to crime and that female criminality is a personal pathology indicative of a biological deficiency or flaw. These biological influences led to particularly cruel forms of criminality in women:

> We have seen that the normal woman is naturally less sensitive to pain than a man.... We also saw that women have many traits in common with children; that their moral sense is deficient; that they are revengeful, jealous, inclined to vengeances of a refined cruelty.
>
> In ordinary cases these defects are neutralized by piety, maternity, want of passion, sexual coldness, by weakness and an underdeveloped intelligence. But when a morbid activity of the physical centers intensifies the bad qualities of women, and induces them to seek relief in evil deeds... it is clear that the innocuous semi-criminal present in the normal woman must be transformed into a born criminal more terrible than any man... the criminal woman is consequently a monster. (pp. 150-152)

The biological determinism underlying Lombroso's work can still be found in more recent accounts of female

criminality (see, for example, Pollak, 1950).[5] These accounts generally rely on two assumptions. Firstly, women who commit criminal offences are motivated by fundamental biological processes such as menstruation[6], menopause and childbirth which upset the hormonal balance of the body. The precise mechanisms by which these biological factors influence socially defined behaviors have not, however, been clearly articulated (Weisheit & Mahan, 1988). In addition, the fact that all women are subject to hormonal changes and yet only a very small proportion of females become criminally deviant is not addressed.

The second assumption is that female biology determines the temperament, intelligence, ability and aggression of women, regardless, one must infer, of any social or environmental factors. As the female temperament is 'naturally' averse to crime, any female involvement in criminal activities is indicative of a physical or mental pathology. As Smart (1977) points out,

> it has become a 'popular' belief that women who commit criminal offences are 'sick' and in need of psychiatric treatment; it is to a much lesser extent that this 'sick' analogy has been adopted in the treatment of men as men are generally assumed to be rationally responsible for their actions while women are not.

---

[5]Note that biological determinism is also reflected in the *Criminal Code* legislation specifically allowing for the court-ordered psychiatric observation of a female defendant charged with infanticide.

[6]See for example Dalton (1961) as well as the rebuttal by Horney (1978).

Smart cites the transformation of Holloway Prison into a secure psychiatric hospital as evidence of this social attitude towards female offenders "who are presumed to be sick and who need help to re-adjust to their appropriate, traditional role" (p. 89). Thus the conception of the problem also prescribes the cure. It should be noted, however, that the "cure" is not wholly benevolent. As Gavigan (1982) points out

> "when women are subjected to 'formal control', they are still dealt with 'informally' through the greater use of probation and psychiatry in their sentencing. This is not to suggest that these 'informal' methods are any less coercive; certainly in the case of psychiatry this could not be seriously maintained" (p. 49).

The perceptions that women are less responsible for their actions, that criminality in women is proof of mental imbalance, and that these women are in need of psychiatric help are consistent with other assumptions about the mental stability of women, many of which originate within the psychiatric profession itself (see, for example, Showalter, 1985). The potential role of psychiatry in the lives of female defendants is, therefore, of particular interest.

Conceptions of Female Mental Health

The history of the interface between the developing mental health and criminal justice systems is marked by a significant expansion in the role and influence of psychiatry in the law over the last century. Much of the impetus to this expansion can be traced to the rise of the asylum system in the nineteenth century and the concurrent

development of the professional status of psychiatry. Scull (1979) argues:

> A dialectical process was at work, whereby the separation of the insane into madhouses and asylums helped to create the conditions for the emergence of an occupational group laying claim to expertise in their care and cure, and the nature and content of the restorative ideal which the latter fostered reinforced the commitment to the institutional approach. (p. 44)

The acceptance of psychiatry's expertise in matters of mental health by Canadian legislators has led to unprecedented reliance on psychiatric opinion in reaching legal decisions pertaining to individuals who are accused of a criminal offence who display behaviors perceived to be symptomatic of mental illness (Conrad & Schneider, 1980). The assessment, treatment and containment of these offenders has become predominantly the domain of forensic psychiatry. Thus, the psychiatric profession may have a considerable influence in the lives of mentally disordered offenders.

Female defendants whose mental capacity is called into question face a system dominated by men who, both as men and as psychiatrists, have been steeped culturally and professionally in contemporary and traditional patriarchal ideologies. The double standard of mental health or normality, a double standard which, like that seen in studies of female criminality, is based on biology, is epitomized by the work of Sigmund Freud (1956) who wrote:

> [Women] refuse to accept the fact of being castrated and have the hope of someday obtaining a penis in spite of everything.... I cannot escape the notion (though I hesitate to give it expression) that for woman the level of what is ethically normal is different from

> what it is in man. We must not allow ourselves to be deflected from such conclusions by the denials of the feminists who are anxious to force us to regard the two sexes as completely equal in position and worth. (cited in Chesler, 1972, p. 76)

This same double standard is reflected in the writings of Carl Jung (1928):

> But no one can evade the fact, that in taking up a masculine calling, studying, and working in a man's way, woman is doing something not wholly in agreement with, if not directly injurious to, her feminine nature....[Female] psychology is founded on the principle of Eros, the great binder and deliverer; while age-old wisdom has ascribed Logos to man as his ruling principle. (cited in Chesler, 1972, p. 77)

Contemporary clinical ideology perpetuates this double standard. At the heart of this ideology is the assumption that only men can be mentally healthy (Chesler, 1972; Penfold and Walker, 1983). The pervasiveness of this assumption in clinical thought is suggested by the responses of seventy-nine clinicians who completed a sex-role stereotype questionnaire (Broverman et al., 1970). The clinicians were asked to characterize a healthy male, a healthy female, and a healthy adult using a number of bipolar items which describe particular behaviors or traits. The authors found: 1) There was high agreement among clinicians as to the attributes characterizing healthy adult men, healthy adult women, and healthy adult, sex unspecified; 2) There were no differences among the men and women clinicians; 3) Clinicians had different standards of health for men and women. Their concepts of healthy mature men did not differ significantly from their concepts of healthy mature adults, but their concepts of healthy mature

women did differ significantly from those for men and for adults. Clinicians were likely to suggest that women differ from healthy men, or healthy adults generally, by being more submissive, less independent, less adventurous, more easily influenced, less aggressive, less competitive, more excitable in minor crises, more easily hurt, more emotional, more conceited about their appearances, less objective, and less interested in math and science.

Clearly, the ethic of mental health in our culture is masculine, and by this standard women are inherently unhealthy mentally. However, behaving in a 'masculine' way does nothing to improve the judgement of a woman's mental health. Rickel's 'angry' women are 'neurotic' because they exhibit behaviors such as

> an inability to brook criticism or competition; bursts of uncontrollable temper; the use of foul language; possessiveness or jealousy; the use of alcohol or drugs; and consorting with spouses who accept such behaviour. (1971, p. 569)

In her persuasive work, Chesler (1972) argues that assumptions about the temperament of women are perpetuated by and in the psychiatric profession which has historically played a significant role in the social control of women for whom less formal, familial controls have failed to secure compliance with assumptions about their proper gender role (see also Penfold & Walker, 1983 and Ehrenreich & English, 1978).

Functional Equivalence or Dual Treatment?

Much debate has centered on the 'functional equivalence' thesis whereby the official statistics showing the greater prevalence of criminality among men and the greater prevalence of mental illness among women are explained by proposing that mental illness in women is the functional equivalent of criminality in men (see, for example, Smart, 1976). Such a hypothesis is based on the conception that female criminality is the result of psychological and/or biological pathology and suggests that female offenders are likely to be viewed as doubly deviant, that is both "mad" and "bad", and deserving compassionate treatment (Chunn & Menzies, 1990). Putting aside for the moment the official statistics which do show relatively greater numbers of mentally ill women and relatively greater numbers of criminal men (Chesler, 1972), the perceived difference in the natures of female and male criminality, that is, the inherent "madness" of female criminality, is based primarily on the evidence that female crimes of violence are often perpetrated in the home against a family member (Rosenblatt & Greenland, 1974). Not all female criminality is violent, however, and as Smart (1976) points out, reliance on official statistics can be misleading. The functional equivalence thesis overlooks the tendency among agencies of social control, both formal and informal, to view and manage female deviance within the 'soft end' of the social control network (Cohen, 1985). From this

perspective, the statistical discrepancies are suggestive of the dual treatment of men and women, that is the criminalization of men and the psychiatrization of women, rather than inherent differences in the forms of male and female deviance.

Within the relatively sparse literature on female offenders ordered by the court to undergo psychiatric assessment which specifically looked at assessment outcomes, the issue of dual treatment has been the source of some controversy. In her ground breaking work on the subject Allen (1987) found that men and women were differentially processed by the forensic system, with men generally viewed as responsible for their actions and therefore morally culpable and deserving of custodial sentencing, while women were generally viewed as pitiable victims lacking moral responsibility for their actions and therefore deserving of treatment and support. However, these findings, Allen argues, do not indicate that the differential outcomes are based solely on the gender of the accused but rather on the characteristics of the accused, male or female, which make him or her appropriate for diversionary treatment. In contrast, two surveys of women assessed at the METFORS clinic in Toronto (Chunn & Menzies, 1990; Menzies, Chunn & Webster, 1992) found no discernable differences in either the characteristics of the males and females assessed or in the assessment outcomes and conclude that in terms of other relevant social factors, such as race and social status, the

male and female subjects were more like one another than those assessing them, regardless of gender. These authors point to the repeated contact of both the female and the male subjects with the agencies of both the criminal justice system and the mental health system as the predominant characteristic in a forensic assessment -- outweighing all other offender attributes. These studies do, however, provide a wealth of anecdotal and impressionistic data suggestive of the ways in which gender roles are reinforced and reproduced in the forensic psychiatric environment.

Characteristics of Women in Forensic Psychiatric Settings

Other more descriptive research into the characteristics of females within the forensic system demonstrates the generally marginal, peripheral status of these women. In one of the few Canadian studies in this area, Hodgins, Hebert, and Baraldi (1986) studied all women (n=29) declared 'insane' under either s. 543 or s. 16 during a two year period in Quebec. These researchers found that the majority of subjects in this cohort were over 30 years of age, poorly educated, and unemployed at the time of the alleged crime. Almost two-thirds of these women were single, divorced, separated or widowed. More than half of the subjects had previously been hospitalized for psychiatric disorders and five had criminal records prior to the current charge. Almost three-quarters of the subjects had committed violent crimes, often directed against a significant other (*e.g.*, a husband or child). One-third of

the cohort who were initially judged incompetent to stand trial were never charged once able to stand trial. All of these subjects were accused of non-violent crimes. Of the remaining two-thirds of the sample, approximately one-third were initially found incompetent and then adjudicated NGRI, and one-third were simply adjudicated NGRI.

The above described piece of research confirms in a Canadian context the findings reported in the larger, although still relatively sparse, American literature. Two of these American studies examined the characteristics of women referred by the court to the Forensic Psychiatry Clinic for the New York Criminal and Supreme Courts for psychiatric evaluation. The first of these (Rosner, Wiederlight, & Wieczorek, 1985) is a descriptive study of 95 females indicted for felonies and referred by the court for psychiatric evaluation over a three year period spanning 1975 through 1977. Like Hodgins, Hebert, and Baraldi (1986), these researchers found that the majority of subjects were charged with crimes of violence, commonly perpetrated against close friends and relatives. Most of the subjects had less than high school education. Almost half of the subjects had received prior mental health services; roughly one-third were diagnosed as schizophrenic and another third were diagnosed as having chronic personality disorders. In contrast to the Hodgins, Hebert, and Baraldi (1986) results, however, in this study the

majority of women were under 30 and over half of the women had a previous arrest record.

In addition to these results, Rosner, Wiederlight, and Wieczorek (1985) also report that the majority of the women in their sample had no religious preference and no active religious affiliation, came from racial and ethnic minority groups, tended to have low-paying jobs, and reported using alcohol (just under one-half reported using drugs).

In the second study of women referred to the Criminal Court section of the Forensic Psychiatry Clinic for psychiatric evaluation, Harmon et al. (1983) examined 76 women, 32 of whom were referred for competency evaluation. In this sample, the majority of women were over 30 years of age, black, single, unemployed, and had less than high school education. Nearly two-thirds of the women in this sample had some previous form of psychiatric treatment (the predominant diagnostic label attached to these women was "personality disordered"). The majority of subjects were charged with felony offences and like the previously described New York study, a great majority of these women had some prior history of criminal charges.

An examination of women forensic patients in a federal hospital in Washington, D.C. (Baridon & Rosner, 1981), obtained similar results to those described above. An analysis of 72 women who were in-patients between September 1977 and December 1978 indicated the typical patient was black, unmarried, in her mid-30's, poorly educated, and

diagnosed as schizophrenic. Over three-quarters of the subjects had a history of psychiatric commitments. Almost one-third of the sample had been charged with a violent offence. A comparison of this sample with a cohort of 72 patients admitted ten years earlier showed that admissions related to public-order and technical offences such as prostitution, parole violations, and drug violations decreased from 50 to 12 percent, while admissions related to crimes of violence rose by 17 percent.

Two studies (Anasseril, Harris, & Husain, 1981; Husain, Anasseril, & Harris, 1983) conducted in Fulton State Hospital in Missouri over a five year period spanning from 1974-1979, examined differences in characteristics between midlife female offenders (40-54 years) and those younger than forty. The first study (Anasseril, Harris, & Husain, 1981), found that the midlife group included a significantly larger number of first-time offenders with a higher frequency of medical as well as psychiatric disorders. None of the women in the midlife group was diagnosed as having antisocial personality disorder, but this was the most common diagnosis among the younger women. The second study (Husain, Anasseril, & Harris, 1983) focused on a subsumable of these women whose current charge was murder. This investigation revealed that the subjects under 40 tended to have low socioeconomic status, have antisocial personality disorder, and/or schizophrenia as psychiatric diagnoses, and most likely kill their children. The midlife women tended

to have slightly higher socioeconomic status, suffer from affective disorder and alcoholism and have more frequent physical disorders, and most likely murder their spouses. A significant finding noted among the midlife women is the high frequency of physical abuse by husbands who later became their homicide victims.

A synthesis of this information indicates that the typical female defendant within the forensic psychiatric system is in her mid 30's, unmarried, poorly educated, has an unstable or nonexistent employment history, has some history of psychiatric treatment and is likely diagnosed as personality disordered, has few, if any, previous criminal convictions and may currently be charged with a violent offence perpetrated against a significant other. Clearly, women who are within the control of the forensic psychiatric system share many of the social attributes that characterize women who have in previous times been subject to the formal control of the state. In the case of these women, however, formal control may involve at one time or another both the criminal justice and the mental health systems.

Research Objectives

The interaction of these two systems in the control of female "madness" and "badness" is worthy of some attention. There are indications that many forensic patients exist in a medico-legal 'twilight zone', receiving little more than "bus therapy" (Toch, 1982), a term that refers to the shuffling of mentally abnormal offenders between the mental

health and criminal justice systems. Menzies and Webster (1987) examined the longitudinal careers of forensic patients and concluded that forensic patents do revolve between the twin systems of control represented by the criminal justice and mental health systems in a recurrent pattern (see also Menzies, 1987). As a unique point of interface between these two systems the forensic psychiatric setting represents an ideal context for the study of this interaction, as well as of the characteristics of the individuals involved.

The literature reviewed here conveys several consistent themes: first, definitions of female deviance frequently involve reference to compliance with gender role norms; second, female deviance is preferably managed through informal means; third, female criminal deviance is evidence of mental instability; and, finally, females are inherently less mentally healthy than males. Taken as a whole these themes suggest that the particular form of the interaction between the criminal justice system and the mental health system might be expected to differ depending on whether the individual is male or female. Specifically, the perceived need to treat as sickness, amenable to psychiatric cure, any female criminality may function to increase the use of the forensic psychiatric system as a point of diversion from the control of the criminal justice system to the less formalized control of the mental health system. Such a diversion may easily be accomplished within this setting,

which as previously described is conducive to flexible decision-making, by the entry of a stay of proceedings by the crown and the initiation of civil commitment procedures by forensic staff.

In the forensic psychiatric setting where both the females and the males have displayed at least some evidence of both "madness" and "badness", the functional equivalence thesis has little to offer in the way of guidance unless it can be demonstrated that the nature of female criminality differs from the nature of male criminality, that is, that the criminality displayed by these women is inherently "mad". As argued here, the relevant issue is whether females and males are processed differentially along the dimension of "madness" and "badness", that is whether they are subject to dual treatment.

This research was undertaken to investigate the characteristics of a relatively large sample of female forensic subjects, and to examine these characteristics in relation to a smaller, representative sample of male forensic subjects in the as yet unexplored jurisdiction of British Columbia. A particular aim of this project was to compare the forensic outcomes of the female and male subjects in order to provide support for the dual treatment hypothesis. Specifically it was expected that a greater proportion of the female than the male subjects would be deemed "mad" and diverted from the authority of the criminal justice system and into the authority of the mental health

system and a greater proportion of the male than the female subjects would be deemed "bad" and returned to court for disposition.

CHAPTER 2

METHODOLOGY

Subjects

During the period covered by the study (March 1, 1979 to June 1, 1988) 1912 individuals were admitted one or more times to the Forensic Psychiatric Institute. Just under 12% (n=223) of these individuals were women.

The female subjects, who were the primary focus of the study, were identified from a list of all female first admissions listed on the registry maintained by the institution.

In order to provide some basis for comparisons, 50 male subjects were also selected from the list of 1689 male first admissions to FPI during the same period, using a systematic sampling procedure with random start (every 34th case with a random start of 14).

The total group of subjects for whom information was collected were admitted to the Forensic Psychiatric Institute for a variety of reasons and by diverse legal means. The methods of admission included: court ordered remand for the primary purpose of assessing fitness to stand trial; court-ordered remand for the purpose of assessing presentence concerns; Lieutenant Governor's warrant of committal following a court finding of unfitness to stand trial; Lieutenant Governor's warrant of committal following a court finding of not guilty by reason of insanity;

involuntary admission under the provisions of the BC *Mental Health Act*; informal admission under the provisions of the BC *Mental Health Act*; temporary absence admissions following certification under the BC *Mental Health Act* and transfer from a correctional facility; and, court-ordered remand for the purpose of assessing pre-trial or trial issues other than fitness to stand trial.

The 223 female subjects had a total of 323 admissions to FPI. One-hundred and sixty-five women had a single admission and 58 had from two to seven admissions. The 50 male subjects had a total of 71 admissions. Twelve men had more than one admission to a maximum of five admissions. In order to simplify the presentation of findings and to ensure that the female and male subjects of this investigation are comparable with respect to legal status at the time of admission as well as with respect to prior contact with FPI, the quantitative results will focus on the characteristics of the female and male subjects at the time of their first fitness assessment admissions. The detailed description and comparison of demographic profiles, social histories, psychiatric histories, criminal histories, alcohol and drug use patterns, current criminal charges, and forensic referral and assessments relates to these admissions of 170 women and 48 men.

Setting

The Forensic Psychiatric Institute is a 121 bed facility located in the suburbs of Vancouver, B.C. The

Institute provides adult inpatient services to individuals with mental disorders who are in conflict with the law. Specifically FPI provides court ordered assessments and is responsible for the custody of individuals remanded for assessment. It also provides treatment and custody for the mentally-ill who are committed to the Institute and aids in the management of the mentally disordered in the criminal justice system. The Forensic Psychiatric Institute is operated by the Forensic Psychiatric Services Commission, whose mandate is granted under the *Forensic Psychiatry Act* (1982), and is funded by the Ministry of Health.

Procedure

For each subject both the legal and medical files were examined. The contents of these files may include some or all of the following: the police report(s); a letter stating the examining doctor's or psychiatrist's jail assessment findings; a probation officer's Pre-Sentence Report(s) and/or contact notes; a Referral Sheet listing the reasons for the admission, usually completed by Crown Counsel; a Social History provided by a Social Worker; a Nursing Assessment completed by a Psychiatric Nurse; Ward Notes kept by psychiatric nursing staff; the examining psychiatrist's letter to the court; a discharge summary or summaries for previous psychiatric hospitalization(s) supplied, with the patient's consent, by the treating psychiatrist; a case summary or summaries for previous outpatient psychiatric or psychological treatment completed

by the psychiatrist or psychologist who provided treatment; and, in many cases, a form letter sent by the Institute to the court requesting disposition information.

During or immediately following examination of these documents information was collected and coded under seven main headings: a) Demographic information: age, religion, education, income source, employment status, occupation, ethnicity, marital status, and number of children; b) Social history: living arrangements-youth, living arrangement-prior to offence, sexual abuse-youth, physical abuse-youth, family psychiatric history, family criminal history, family alcohol/drug abuse, sexual abuse-adult, and physical abuse-adult; c) Psychiatric history: age at first manifestation of mental illness, age at first treatment, number of admissions to a psychiatric hospital, previous forms of outpatient care, IQ, number of suicide attempts, and suicidal ideation; d) Criminal history: previous criminal charge, offence type, previous detention-remand, previous criminal conviction, offence type, previous detention-incarceration; e) Alcohol and drug use patterns: alcohol, controlled substances, non-prescription drugs, prescription drugs, drug use at time of offence, and alcohol use at time of offence; f) Current Offence(s): criminal charge(s) related to present admission, victim information, and weapons use; g) Forensic referral and assessment information: jail assessment information, referral source, opinion requested, opinion given dangerousness,

dangerousness rating, admission number, readmisssion type, admission date, legal status at admission, diagnosis at admission, characteristics of condition, onset of condition, precipitating stress, length of stay, institutional behavior (critical incidents), discharge date, discharge status, status change during admission, date of status change, diagnosis at discharge, treatment recommendations, disposition recommendations, and disposition. See appendix I for the coding manual used to collect this data. See appendix II for the codes used to record current criminal charges.

The majority of the file coding was done by the author. Some files were coded by an assistant under direct supervision. No reliability data were collected.

The individual subjects at the time of a single FPI admission for the assessment of fitness will form the basic unit of analysis. However, in some cases involving multiple admissions, greater detail was collected in note form, but devoid of identifying references, in order to capture and convey the longitudinal process experienced by some subjects (*e.g.*, repeated referrals for the assessment of the accused in relation to pre-trial, trial, sentencing, and post-sentencing issues; admissions resulting from warrants of committal following a finding of unfitness; becoming fit; and, admissions resulting from warrants of committal following a finding of not guilty by reason of insanity).

From these notes, several abbreviated case studies of both female and male subjects will be presented.

Qualitative material was also extracted during the review of the forensic records of the female subjects. These illustrations will be used in order to provide a contextual background for the discussion of the quantitative findings.

CHAPTER 3

RESULTS

The quantitative results relating to the fitness assessment admissions of 170 women and 48 men will be presented first. Following this examination, the longitudinal forensic careers of selected subjects will be explored through the presentation of several brief case studies.

Demographic Profile

The mean age at admission for the female subjects was 32.5 years (SD 10.8) with a range of 52.5 years from 16.8 to 69.3 years and a median age of 31.1 years. The mean age of the male subjects was slightly, but not significantly, less at 31.4 years (SD 13.1) with a range of 54.9 years from 16.8 to 71.7 years and a median age of 26.8 years.

The majority of both the female and the male subjects for whom ethnicity was recorded were of white ethnic origin (76.9% and 87.5%, respectively). The second largest ethnic group was Native Indian accounting for 16.9% of the females and 6.3% of the males.

The female and male subjects for whom the information was known were somewhat dissimilar with regard to religious background both in terms of childhood experience and current practice. Specifically, at the time of the subject's first remand for fitness assessment, slightly fewer females than males were Protestant (31.3% and 37.5%, respectively), more women than men were Catholic (38.9% and 25%, respectively),

and fewer women than men practiced no religion (18.3% and 32.5%, respectively).

With respect to educational background the female and male subjects were somewhat different ($x^2(2)=5.36$, $p=.069$). Specifically 63 women (37.3%) and 26 men (54.2%) had elementary school education or less than elementary school education. In contrast, 75 women (44.4%) and 13 men (27.1%) had completed secondary school education. Equal proportions of female and male subjects had received some form of post secondary education (18.3% and 18.8%, respectively).

An equal proportion of female and male subjects were married or living in a common law relationship at the time of their admission (19.4% and 18.8% respectively). However, a larger proportion of the men had never been married (54.2% compared to 44.7% of the women) and a larger proportion of the women were separated, divorced or widowed (35.9% compared to 27.1% of the men). The majority of both the females and the males who had ever married had been married only once (73.9% and 77.3%, respectively). Of the subjects who had ever been married the female subjects were significantly younger than the male subjects at the time of their first marriage (Mean 21.8 years, SD 4.6 and Mean 24.1 years, SD 4.2, respectively, $t(102)=1.98$, $p=.050$).

The female subjects were significantly more likely than the male subjects to have at least one child at the time of admission to FPI ($x^2(1)=5.22$, $p<.05$). The average number of children born to all of the female subjects was 1.31

compared to an average of .82 children born to all of the male subjects ($t(203)=-1.95$, $p<.05$). This difference disappears, however, when only those female and male subjects who had had children are considered (M=2.12 and M=1.90, respectively). With reference to all subjects, there was also no difference in the number of children (including step-children) in the subject's custody at the time of the offence which led to the current FPI admission (M=.33 for females and M=.20 for males).

With respect to occupational level, the largest proportion of both the female and the male subjects had been employed in unskilled jobs (31.6% and 56.5%, respectively), however, the charts of significantly more women than men contained no reference to previous employment and/or occupational level (25.3% of women and 10.4% of men; $x^2(1)=4.83$, $p<.05$). An additional 27 women (17.4%) were considered homemakers or students. The remaining subjects had been employed in semi-skilled, skilled, or professional-managerial occupations (21.9% of females and 32.6% of males).

The large majority of both the female and the male subjects were considered unemployed at the time of the offence which led to the current admission to FPI (76.4 and 82.6%, respectively)

Source of income at the time of the offence which led to the current admission to FPI was for the large majority of both the female and the male subjects some form of

government allowance, such as welfare, unemployment insurance benefits, social security or pension payments, or other government allowance (70.3% of females and 73.7% of males). A larger proportion of the female subjects depended on a family member for their income (11.6% of females and 2.6% of males) and a smaller proportion were supporting themselves (11.6% of females and 21.1% of males).

In summary, the female and male subjects were by in large similar with respect to their age at admission, ethnicity, religion, education, marital status at admission, employment status and income source. The female and male subjects differed significantly in the following respects: first, of the subjects who had ever married, the females married at an earlier age; second, the females were more likely to be parents; and, third, the females were more likely to have no occupational history.

Social History

Information concerning living arrangements during the subject's youth, that is prior to eighteen years of age, was available for approximately 80% of both the female and the male subjects. In comparing these subjects, a significantly larger proportion of the female subjects than the male subjects had had a stable family environment, at least in this sense, characterized by a single type of living arrangement throughout their youth (72.3% and 50.0%, respectively; $x^2(1)=7.08$, $p<.01$). As shown in Table 1 below approximately equal proportions of the female and male

Table 1

Living arrangements prior to eighteen years of age by sex

Living arrangements	Sex: Male		Sex: Female	
Other..................	3	7.5%	8	5.7%
Natural parents........	35	87.5%	118	83.7%
Mother.................	13	32.5%	14	9.9%
Father.................	2	5.0%	5	3.5%
Adoptive parents.......	3	7.5%	8	5.7%
Foster parents.........	5	12.5%	20	14.2%
Grand parents..........	1	2.5%	3	2.1%
Multiple placements....	20	50.0%	39	27.7%
Step-natural parent....	6	15.0%	15	10.6%
Total Cases............	40	100.0%	141	100.0%

Percentages sum to more than 100% because more than one category may apply in any single case.

subjects had spent at least some of their youth living with both of their natural parents, with their natural fathers alone, with one natural parent who had remarried, with adoptive parents, with foster parents, and with grandparents. However, a much larger proportion of males than females had spent at least some of their youth living with their natural mothers alone.

With regard to sexual abuse prior to the age of eighteen, a larger percentage of the women had experienced some type of sexual abuse during their youth (36 women or 21.2% of the females compared to 6 men or 12.5% of the males). The perpetrator of this abuse was unknown in 33.3% of the male cases and 8.3% of the female cases, however, when the identity of the perpetrator was known, the largest proportion of the women (75%) were abused by family members (the woman's father in 48% of these cases) while the largest proportion of the men were abused by non-family members (75%).

Equal proportions of the female and male subjects had been subjected to physical abuse during their youth (18.2% and 18.8%, respectively). The perpetrator of the abuse was unknown in 9.7% of female cases, however when the identity of the perpetrator was known, the largest proportion of both the female and the male subjects were abused by a family member (89.3% and 88.9%, respectively), the subject's father in 60% and 75% of these cases, respectively.

Psychiatric illness, as evidenced by a psychiatric diagnosis or an admission to a psychiatric hospital or ward, was present, in at least one family member, in approximately equal proportions of the families of the female and the male subjects (21.2% and 22.9%, respectively). However, the family member who exhibited the illness differed for the female and the male subjects. The family member most frequently affected in the families of the female subjects was the subject's mother (15.9% of cases compared to 10.4% of the male cases). The family member most frequently affected in the families of the male subjects was the subject's father (18.8% of cases compared to 7.1% of the female cases). Siblings of the female subjects exhibited psychiatric illness more frequently than the siblings of the male subjects (12.4% and 4.2%, respectively) and other family members exhibited psychiatric illness in equal proportions (12.4% of female cases and 12.5% of male cases).

Information concerning the criminal history of the subject's family was largely unavailable (92.9% of female cases and 79.2% of male cases). With reference to all cases, a slightly greater proportion of the male subjects belonged to families in which one or more members had been convicted of some type of criminal offence (12.5% compared to 7.1% of the female subjects).

A history of substance abuse in at least one family member was documented in a larger proportion of male cases than female cases (29.2% and 18.8%, respectively). Although

the family member most frequently involved in the families of both the female and the male subjects was the subject's father (27.1% and 33.3%, respectively), a much larger proportion of the spouses of the female subjects than the male subjects had a history of substance abuse (17.1% of females compared to 6.3% of males). Siblings of the male subjects had a history of substance abuse in slightly larger proportions than the female subjects (16.7% and 12.4%, respectively) and the subject's mother was involved in approximately equal proportions of 15.9% of the female cases and 16.7% of the male cases.

With reference to the 167 women and 46 men who were eighteen years old or more at the time of the current admission to FPI, 18 women (10.8%) had been victims of sexual abuse as an adult compared to one man (2.2%). Of the women who had been abused, 38.9% had been abused by their spouse, 16.7% each had been abused by their father, or a stranger, or was an unknown assailant, and 11.1% had been abused by a friend or acquaintance. The single male victim had been abused by a stranger.

With reference to the subjects who were adults at the time of the current admission to FPI, 46 women (27.5%) and no men had been victims of physical abuse ($x^2(1)=16.16$, $p<.0001$). Of the women who had been abused, 78.3% had been abused by their spouse, 15.2% had been abused by a friend or acquaintance, and 6.5% had been abused by their fathers.

The female and male subjects differed significantly in terms of their living arrangements at the time of the offence which led to the current admission to FPI ($x^2(5)=16.96$, $p<.01$). As shown in Table 2, many more of the women than of the men were living alone or with children alone, and many more of the men than of the women were living with parents or other relations.

In summary, the female and male subjects were by in large similar with respect to sexual and physical abuse prior to the age of eighteen, the presence of psychiatric illness, substance abuse and criminal history among family members, and sexual abuse during adulthood. The female and male subjects differed significantly in the following respects: first, the female subjects had more stable living arrangements prior to the age of eighteen; second, the female subjects were more likely to have been victims of physical abuse during adulthood; and, third, the female subjects were more likely to have been living alone or with children alone at the time of the offence which led to the current admission to FPI.

Psychiatric History

Psychiatric illness manifested itself slightly, but not significantly, earlier in the lives of the men than in the lives of the women (M=19.73 years, SD=10.98 for the men and M=21.31 years, SD=10.43 for the women), but the age at which the illness was first treated was almost identical for the two groups (M=23.33 years, SD=10.69 for the men and M=23.49

Table 2

Living arrangements at time of offence by sex

Living arrangements (Count / Col Pct)	Sex: Male	Female	Row Total
Other	8 17.0	24 14.4	32 15.0
Alone	9 19.1	55 32.9	64 29.9
Spouse or spouse and children	9 19.1	27 16.2	36 16.8
Parents or other relatives	13 27.7	14 8.4	27 12.6
Alone with children		11 6.6	11 5.1
No fixed address	8 17.0	36 21.6	44 20.6
Column Total	47 22.0	167 78.0	214 100.0

years, SD=9.37 for the women). The difference in the time elapsed for the male and the female subjects between the manifestation and the treatment of psychiatric illness was not, however, significant.

Over seventy-five percent of the women compared to just over half of the men had had at least one admission to a psychiatric hospital or ward prior to the current FPI admission. The mean number of admissions across all subjects was 3.42 (SD=3.56) for the females and 2.4 (SD=3.43) for the males. This difference approaches but does not reach significance ($t(206)=-1.76$, $p=.08$).

At the time of admission to FPI 95 women (55.9%) and 23 men (47.9%) had previously received at least one form of outpatient care. Of these subjects a larger proportion of the females than of the males had received more than one form of outpatient care prior to the admission to FPI (30.5% of the females compared to 17.4% of the males). As shown in Table 3, of the subjects who had received some form of care, and with reference to all instances of care, a larger proportion of the female subjects than the male subjects had been involved with a community care team, and/or with the outpatient department of a general hospital.

With reference to the subjects who had been tested, the intelligence scores of the majority of both the female (90%) and the male (82.9%) subjects were in the average range. Slightly more of the males than of the females scored in the retarded range (14.6% of males compared to 8.5% of females).

Table 3

Previous outpatient care by sex

Previous outpatient care	Sex: Male		Female	
Other			7	7.4%
Mental health centre	7	30.4%	25	26.3%
Community care team	3	13.0%	25	26.3%
Outpatient dept.-Riverview			1	1.1%
Outpatient dept.-Other	1	4.3%	4	4.2%
Outpatient dept.-General	1	4.3%	13	13.7%
Private therapy-psychiatrist	12	52.2%	49	51.6%
Private therapy-other	1	4.3%	7	7.4%
Forensic clinic	2	8.7%		
Total Cases	23	100.0%	95	100.0%

Percentages sum to more than 100% because more than one category may apply in any single case.

Information concerning suicide attempts was available for approximately half of both female and male subjects. Of the 85 women and 25 men for whom the information was known, over half of each group had made at least one suicideattempt (56.5% of females and 56% of males). Among the females the number of suicide attempts ranged from zero to fourteen with a mean of 1.46 (SD=2.39). Among the males the number of suicide attempts ranged from zero to eight with a mean of 1.36 (SD=2.22).

Suicidal ideation was significantly more prevalent among the female subjects than among the male subjects ($x^2(3)=10.15$, $p<.05$). Over half of the males (53.5%) denied any suicidal thoughts compared to 37.3% of the females. Conversely, just over thirty percent of the female subjects reported frequent suicidal ideation compared to only seven percent of the male subjects. Approximately twenty-five percent of each group reported occasional suicidal thoughts, and approximately twice the proportion of males than females reported having suicidal thoughts rarely (14% of males and 7.8% of females).

In summary, the female and male subjects were on the whole similar with respect to the age at first manifestation and treatment of mental illness, psychiatric hospitalizations, previous outpatient care, intelligence, and suicide attempts. The only significant difference in terms of the psychiatric history of the female and the male

subjects lay in the greater frequency of suicidal ideation among the female subjects.

Criminal History

A significantly greater proportion of the male subjects (87.5%) than the female subjects (52.4%) had been previously charged with at least one criminal offence ($x^2(1)=19.28$, $p<.0001$). Of these 89 female subjects and 42 male subjects, a larger proportion of the males than the females had been charged with a personal/violent offence (42.9% of males compared to 25.8% of females), but a larger proportion of the females than the males had been charged with property offences (47.2% of females and 40.5% of males) and public order offences (21.3% of females and 11.9% of males). Of the 89 females charged 24.7% were remanded into custody awaiting trial compared to 11.9% of the 42 males charged.

A significantly greater proportion of the male subjects (79.2%) than the female subjects (30.6%) had been previously convicted of at least one criminal offence ($x^2(2)=36.48$, $p<.00001$). One woman had previously been found not guilty by reason of insanity. Of the 52 female subjects and 38 male subjects previously convicted, larger proportions of the males had been convicted of personal/violent offences (31.6% compared to 28.8% of the females) and property offences (50% compared to 46.2% of the females), but a greater proportion of the female subjects (21.2%) than the male subjects (10.5%) had been previously convicted of public order offences. Of the 52 females convicted 59.6%

received custodial sentences compared to 68.4% of the 38 males.

In summary, the male subjects were significantly more likely than the female subjects to have been charged and convicted of a criminal offence prior to the current FPI admission.

Alcohol and Drug Use Patterns

A significantly greater proportion of the male subjects compared to the female subjects had a history of alcohol abuse ($x^2(4)=22.28$, $p<.001$). Seventy-five percent of the men had a history of alcohol abuse compared to 45.1% of the women. Alternatively, only one male (2.3%) did not use alcohol at all compared to 20.4% of the females.

The abuse of street drugs was also significantly more prevalent among the male subjects than among the female subjects ($x^2(4)=14.40$, $p<.01$). Of the males, 61.9% had a history of drug abuse compared to 34.2% of the females. Alternatively, 23.8% of the males had no history of drug abuse compared to 36.8% of the females.

With respect to the abuse of non-prescription and prescribed drugs, 14.5% of the male sample, compared to 4.1% of the female sample, had a history of abusing non-prescription drugs, and 12.5% of the male sample, compared to 10% of the female sample, had a history of abusing prescribed drugs.

Alcohol use at the time of the offence leading to the current admission to FPI was significantly more likely among

the male subjects than among the female subjects ($x^2(1)=17.29$, $p<.0001$). Of the males, 45.8% were under the influence of alcohol at the time of the offence compared to 17.1% of the females.

The use of street drugs at the time of the offence leading to the current admission to FPI was also significantly more prevalent among the male subjects than among the female subjects ($x^2(1)=16.70$, $p<.0001$). Of the male subjects, 25% were under the influence of one or more street drugs at the time of the offence compared to 5.3% of the female subjects.

In summary, the female and male subjects were similar with respect to the abuse of non-presciption and prescribed drugs but differed significantly with respect to the abuse of alcohol and street drugs, and with respect to the use of alcohol and street drugs at the time of the offence which led to the current FPI admission.

Current Offence(s)

The male subjects had significantly more charges relating to the current FPI admission than the female subjects. The mean number of charges for the male subjects was 2.23 (SD=1.12) compared to a mean of 1.86 (SD=1.03) for the female subjects ($t(216)=2.16$, $p<.05$). The types of charges which led to the current admission to FPI are presented in Table 4. When all charges are collapsed into serious offences (murder, manslaughter, attempted murder, sexual assault serious assault, kidnapping or abduction,

Table 4

Current criminal offence(s) by sex

Current criminal offence(s)	Sex			
	Male		Female	
Murder	6	12.5%	12	7.1%
Manslaughter			1	.6%
Attempted murder	2	4.2%	10	5.9%
Sexual assault	8	16.7%	1	.6%
Other sexual offence	6	12.5%		
Serious assault	13	27.1%	37	21.8%
Kidnapping/abduction			5	2.9%
Common assault	7	14.6%	23	13.5%
Driving assaults	1	2.1%	13	7.6%
Robbery	1	2.1%	9	5.3%
Offensive weapons	7	14.6%	28	16.5%
Arson	3	6.3%	15	8.8%
Property damage	11	22.9%	38	22.4%
Public order	18	37.5%	47	27.6%
Other Acts			1	.6%
Theft	21	43.8%	74	43.5%
Drug offences	3	6.3%	2	1.2%
Total Cases	48	100.0%	170	100.0%

Percentages sum to more than 100% because more than one category may apply in any single case.

robbery, weapons offences, and arson) and minor offences (other sexual offences, common assault driving assaults, property damage, public order offences, theft, drug offences, and violations of other Acts) there is no significant difference between the female and male subjects with respect to the seriousness of the charges against them ($x^2(1)=.07$, $p=.78$).

Just under half (48.2%) of the female subjects had been charged with at least one criminal offence involving a victim compared to just over half (54.2%) of the males. With reference to these subjects, the charges brought against the male subjects involved a significantly greater number of victims than those brought against the female subjects (M=1.69, SD=.97 for the males compared to M=1.26, SD=.54 for the females: $t(106)=2.91$, $p<.01$). As shown in Table 5 the type of victims involved differed for the male and the female subjects. The large majority of the victims of the male subjects' crimes were strangers followed by the children of others and then the subject's own parent. In contrast, while the largest proportion of victims of the female subjects' crimes were also strangers, a larger proportion of female subjects than male subjects had victimized friends or acquaintances and their own children.

Approximately one-third of both the female and the male subjects had been charged with at least one criminal offence which involved the use of a weapon (30% and 33.3%, respectively). Of these subjects, over half of the females

Table 5

Victim(s) by sex

Victim type	Sex: Male		Sex: Female	
Other			4	4.9%
Stranger	21	80.8%	30	36.6%
Police officer	5	19.2%	17	20.7%
Friend-acquaintance	3	11.5%	18	22.0%
Spouse	1	3.8%	4	4.9%
Own child			16	19.5%
Parent	4	15.4%	5	6.1%
Sibling	1	3.8%		
Other family member	1	3.8%	4	4.9%
Unknown			2	2.4%
Other child	8	30.8%	2	2.4%
Total Cases	26	100.0%	82	100.0%

Percentages sum to more than 100% because more than one category may apply in any single case.

(58.8%) had used a knife compared to 43.8% of the males. In contrast, one-quarter of the males, compared to 11.8% of the females had used a firearm in the commission of the offence. A larger proportion of the males (31.3%) than the females (21.6%) had used a household item (eg., electrical cord, rope, frying pan, etc.) as a weapon and four women (7.8%) had used poison or explosives.

In summary, although the female and male subjects were quite similar in terms of the types of criminal charges pending at the time of the admission to FPI, the men had significantly more charges against them and the charges related to offences which involved significantly more victims.

<u>Forensic Referral and Assessment</u>

A significantly larger proportion of the male subjects (60.4%) than the female subjects (31.4%) had had a psychiatric assessment while in jail prior to admission to FPI ($x^2(1)=13.11$, $p<.001$). Of these 50 female subjects and 29 male subjects, the agency which had requested the jail assessment was unknown in almost half of the female cases (46%) and almost one-third of male cases (31%). Of the remaining cases, crown counsel was the agency which had requested the jail assessment in 70.4% of the female cases and 90% of the male cases.

The agency which initiated the referral to FPI was unknown in the case of three females and one male. Of the remaining 167 females and 47 males, the agency which

initiated the referral to FPI was crown counsel in the majority of both female (74.3%) and male cases (70.2%). Slightly more females (23.4%) than males (19.1%) had been referred by the judge or court and four men (8.5%) and no women had been referred by defence counsel.

The psychiatric opinion requested by the referral agency was unknown in the cases of thirteen female subjects (7.6%) and in the cases of three male subjects (6.3%). Table 6 presents all of the opinions requested in relation to all subjects for whom this information was known. The mean number of opinions requested for the female subjects is 3.82 compared to a mean of 4.4 for the male subjects. This difference was not significant.

An opinion regarding the subject's dangerousness was provided for 36 (21.2%) of the female subjects and 9 (18.8%) of the male subjects. With reference to these subjects, equal proportions of 77.8% of both the female and the male subjects were considered dangerous. However, while all of these men were considered dangerous to others, 35.7% of the females were considered dangerous to themselves.

The initial diagnosis or diagnoses assigned to the subjects following admission to FPI are presented in Table 7. A larger proportion of the female subjects than the male subjects were diagnosed with a schizophrenic or a mood disorder, while a larger proportion of the male subjects compared to the female subjects were diagnosed with a

Table 6

Opinion(s) requested by sex

Opinion(s) requested	Sex			
	Male		Female	
Existence of mental illness..	30	66.7%	96	61.1%
Fitness......................	45	100.0%	157	100.0%
Mental state at offence......	33	73.3%	95	60.5%
Treatment needs..............	25	55.6%	72	45.9%
Social assessment............	18	40.0%	46	29.3%
Personality assessment.......	24	53.3%	64	40.8%
Presentence report...........	23	51.1%	69	43.9%
Total Cases..................	45	100.0%	157	10.0%

Percentages sum to more than 100% because more than one category may apply in any single case.

Table 7

Diagnosis at admission by sex

Diagnosis at admission	Sex: Male		Female	
Conduct disorders............	1	2.1%		
Impulse control..............			1	.6%
Retardation..................	1	2.1%	10	5.9%
Alcohol related psychoses....			2	1.2%
Drug related psychoses.......	1	2.1%	1	.6%
Schizophrenia................	16	33.3%	77	45.3%
Organic psychoses............	2	4.2%	8	4.7%
Mood disorders...............	4	8.3%	26	15.3%
Paranoid disorders...........	5	10.4%		
Other psychoses..............	1	2.1%	5	2.9%
Neurotic disorders...........	1	2.1%	8	4.7%
Personality disorders........	21	43.8%	60	35.3%
Sexual disorders.............	2	4.2%	1	.6%
Drug dependence..............	4	8.3%	3	1.8%
Alcohol dependence...........	5	10.4%	9	5.3%
Non-dependant drug use.......	12	25.0%	24	14.1%
Adjustment disorders.........			5	2.9%
Eating disorders.............			1	.6%
Diagnosis deferred...........			2	1.2%
No diagnosis.................	1	2.1%	4	2.4%
Total Cases..................	48	100.0%	170	100.0%

Percentages sum to more than 100% because more than one category may apply in any single case.

personality disorder or a type of alcohol or drug use disorder.

The mean length of stay for the female subjects under remand status was 22.18 days (SD=12.08) with a minimum stay of 2 days and a maximum stay of 95 days, compared to a mean length of stay for the male subjects under remand status of24.08 days (SD=8.16) with a minimum stay of 8 days and a maximum stay of 51 days. However, when total length of stay, including length of stay following a change in status, for the current admission is considered the mean length of stay for the female subjects becomes 61.69 days (SD=262.27) with a minimum stay of 2 days and a maximum stay of 3379 days, compared to a mean length of stay for the male subjects of 31.94 days (SD=21.37) with a minimum stay of 8 days and a maximum stay of 112 days. This difference in total length of stay for females and males admitted for the primary purpose of assessing fitness to stand trial, was not, however, significant.

In almost every category of institutional behaviors considered critical incidents a greater proportion of the female subjects than the male subject were involved. Nine women (5.3%) had escaped from FPI at least once during the course of the admission compared to one (2.1%) of the male subjects. Almost one-quarter (23.5%) of the female subjects compared to 14.6% of the male subjects had committed at least one assault during the course of the FPI admission. Of these 40 females and 7 males, 60% of the females,

compared to 14.3% of the males, had assaulted a staff member only, 30% of the females, compared to 42.9% of the males, had assaulted another patient only, and 7.5% of the women, compared to 28.6% of the males, had assaulted both a staff member and another patient. One woman (.6%) and no men had been seriously injured during the course of the admission. Ten women (5.9%) and no men had inflicted injury on themselves at least once during the course of the admission. Twenty-nine women (17.1%) and two men (4.2%) had done property damage at least once during the course of the admission. The only exception to this trend was found in relation to subjects who had been assaulted by another patient at least once during the admission. Five men (10.4%) compared to ten women (5.9%) had been so assaulted.

The final diagnosis or diagnoses assigned to the subjects at the time of discharge is presented in Table 8. As was found with admission diagnosis, a larger proportion of the female subjects than the male subjects had been diagnosed with a schizophrenic or mood disorder and a larger proportion of the male subjects than the female subjects had been diagnosed with a personality disorder or a type of alcohol or drug use disorder. However, when all diagnoses are collapsed into psychotic and non-psychotic disorders there is no significant difference between the female and male subjects with respect to the seriousness of the diagnosis ($x^2(1)=.36$, $p=.55$)

Table 8

Diagnosis at discharge by sex

Diagnosis at discharge	Sex: Male		Sex: Female	
Conduct disorders	1	2.1%		
Impulse control			1	.6%
Retardation	1	2.1%	9	5.3%
Alcohol related psychoses			2	1.2%
Drug related psychoses	1	2.1%	1	.6%
Schizophrenia	16	33.3%	76	44.7%
Organic psychoses	2	4.2%	8	4.7%
Mood disorders	4	8.3%	26	15.3%
Paranoid disorders	5	10.4%		
Other psychoses	1	2.1%	5	2.9%
Neurotic disorders	1	2.1%	8	4.7%
Personality disorders	20	41.7%	60	35.3%
Sexual disorders	2	4.2%	1	.6%
Drug dependence	4	8.3%	3	1.8%
Alcohol dependence	5	10.4%	9	5.3%
Non-dependant drug use	12	25.1%	24	14.1%
Adjustment disorders			5	2.9%
Eating disorders			1	.6%
Diagnosis deferred			2	1.2%
No diagnosis	2	4.2%	5	2.9%
Total Cases	48	100.0%	170	100.0%

Percentages sum to more than 100% because more than one category may apply in any single case.

The statuses of the subjects at the time of discharge from FPI is presented in Table 9. A significantly larger proportion of the male subjects compared to the female subjects were returned to court with the recommendation that they be found fit to stand trial or were released into their own care, and a significantly larger proportion of the female subjects compared to the male subjects became involuntary (41 women) or informal (4 women) patients under the provisions of the BC *Mental Health Act* during their FPI admission ($x^2(4)=17.61$, $p<.01$). Similar proportions of the female and male subjects were returned to court with the recommendation that they be found unfit to stand trial.

This relationship between discharge status and the subject's gender is, however, meditated by the seriousness of the precipitating charges. Tables 9a and 9b depict the discharge statuses of the female and male subjects who had been charged with serious offences (murder, manslaughter, attempted murder, sexual assault serious assault, kidnapping or abduction, robbery, weapons offences, and arson) and with minor offences (other sexual offences, common assault driving assaults, property damage, public order offences, theft, drug offences, and violations of other Acts), respectively. Among those subjects charged with serious offences (67 women and 20 men) there was no significant association between discharge status and gender. Only among those subjects charged with minor offences (103 women and 28

Table 9

Discharge status by sex

Discharge status (Count / Col Pct)	Sex: Male	Sex: Female	Row Total
Other		3 1.8	3 1.4
Remand-fit	35 72.9	90 52.9	125 57.3
Remand-unfit	6 12.5	24 14.1	30 13.8
Involuntary/ Informal	1 2.1	45 26.5	46 21.1
Care of self	6 12.5	8 4.7	14 6.4
Column Total	48 22.0	170 78.0	218 100.0

Table 9a

Discharges statuses of subjects charged with serious offences by sex

Discharge status (Count / Col Pct)	Sex: Male	Sex: Female	Row Total
Other		2 3.0	2 2.3
Remand-fit	16 80.0	38 56.7	54 62.1
Remand-unfit	3 15.0	18 26.9	21 24.1
Involuntary/ Informal		7 10.4	7 8.0
Care of self	1 5.0	2 3.0	3 3.4
Column Total	20 23.0	67 77.0	87 100.0

Table 9b

Discharge statuses of subjects charged with minor offences by sex

Discharge status (Count / Col Pct)	Sex: Male	Sex: Female	Row Total
Other		1 1.0	1 .8
Remand-fit	19 67.9	52 50.5	71 54.2
Remand-unfit	3 10.7	6 5.8	9 6.9
Involuntary/ Informal	1 3.6	38 36.9	39 29.8
Care of self	5 17.9	6 5.8	11 8.4
Column Total	28 21.4	103 78.6	131 100.0

men) does the relationship between these variables persist ($x^2(4)=14.27$, $p<.01$).

The treatment recommendations made by the examining psychiatrists to the court are presented in Table 10. The predominant recommendation for both the female and the male subjects was to continue taking prescribed medications. However, a larger proportion of the recommendations relating to the male subjects, compared to the recommendations relating to the female subjects, were for the subject to abstain from alcohol and drugs and to seek individual therapy or supervision and a larger proportion of the recommendations relating to the female subjects, compared to the recommendations relating to the male subjects, were for the subject to seek community outpatient care.

The dispositional recommendations made by the examining psychiatrists to the court are presented in Table 11. No dispositional recommendation was made for a larger proportion of the male subjects compared to the female subjects. A larger proportion of the recommendations relating to the female subjects, compared to the recommendations relating to the male subjects, were for the subject to seek community outpatient care, psychiatric hospitalization, or to return to FPI for further assessment. In contrast, a larger proportion of the recommendations relating to the male subjects, compared to the recommendations relating to the female subjects, were for the subject to receive probation upon conviction, or for the

Table 10

Treatment recommendations by sex

Treatment recommendations	Sex			
	Male		Female	
Other			4	2.4%
Medication	18	37.5%	71	41.8%
Abstain alcohol/drugs	13	27.1%	17	10.0%
Individual therapy-supervision	10	20.8%	14	8.2%
Group therapy			2	1.2%
Community outpatient care	2	4.2%	31	18.2%
Forensic Clinic	4	8.3%	14	8.2%
Return FPI-further treatment	2	4.2%	15	8.8%
Multiple	13	27.1%	40	23.5%
None	15	31.3%	47	27.6%
Total Cases	48	100.0%	170	100.0%

Percentages sum to more than 100% because more than one category may apply in any single case.

Table 11

Dispositional recommendations by sex

Dispositional recommendations	Sex: Male		Sex: Female	
Other			1	.6%
Forensic Clinic	3	6.3%	10	5.9%
Community outpatient.care	4	8.3%	35	20.6%
Psychiatric hospital	1	2.1%	28	16.5%
Return FPI-further assessment			16	9.4%
Custodial setting	1	2.1%	1	.6%
Bail			4	2.4%
Probation	6	12.5%	11	6.5%
Stay charges-involuntary	3	6.3%	9	5.3%
Stay charges-informal			1	.6%
Multiple	4	8.3%	14	8.2%
WOC-unfit	4	8.3%	7	4.1%
Reside in group home	3	6.3%	5	2.9%
None	28	58.3%	56	32.9%
Total Cases	48	100.0%	170	100.0%

Percentages sum to more than 100% because more than one category may apply in any single case.

subject to be returned to FPI under a Warrant of Committal following a court finding of unfitness to stand trial.

The dispositions of the cases, when they were known, are presented in Table 12. A larger proportion of the female cases, compared to the male cases, were disposed of with the crown entering a stay of proceedings in relation to the charges and the woman becoming an involuntary patient under the provisions of the BC *Mental Health Act*, with the crown simply entering a stay of proceedings in relation to the charges, with the women returning to FPI for further assessment, and with the woman entering a psychiatric hospital. In contrast, a much larger proportion of the male cases, compared to the female cases, were disposed of with the man receiving a custodial sentence upon conviction, and with the man returning to FPI under a Warrant of Committal following a court finding of unfitness to stand trial.

As shown in Tables 12a and 12b the separation of subjects charged with serious offences from those charged with minor offences alters this dispositional picture to some extent but, unlike what was seen with respect to discharge status, the seriousness of the offence does not appear to strongly mediate the relationship between ultimate disposition and gender.

In summary, the female and male subjects were, on the whole, similar in terms of referral source, opinion(s) requested, dangerousness rating, diagnosis, length of stay, institutional behaviors, treatment recommendations, and

Table 12

Disposition by sex

Disposition	Sex: Male		Sex: Female	
Other	4	10.8%	12	8.6%
Forensic Clinic			4	2.9%
Community outpatient care	1	2.7%	4	2.9%
Psychiatric hospital			13	9.3%
Return FPI-further assessment	1	2.7%	15	10.7%
Custodial setting	13	35.1%	17	12.1%
Bail	2	5.4%	3	2.1%
Probation	7	18.9%	31	22.1%
Stay charges-involuntary	7	18.9%	43	30.7%
Charges stayed	1	2.7%	18	12.9%
Charges withdrawn/dismissed	1	2.7%	4	2.9%
Multiple	5	13.5%	33	23.6%
WOC-unfit	4	10.8%	8	5.7%
WOC-ngri			2	1.4%
Not guilty-discharged	1	2.7%	2	1.4%
Total Cases	37	100.0%	140	100.0%

Percentages sum to more than 100% because more than one category may apply in any single case.

Table 12a

Disposition of subjects charged with serious offences by sex

Disposition	Sex: Male		Sex: Female	
Other	1	6.7%	4	7.3%
FPC-outpatient care			2	3.6%
Community outpatient			2	3.6%
Psychiatric hospital			1	1.8%
Return FPI-further assessment			10	18.2%
Custodial setting	7	46.7%	8	14.5%
Bail			2	3.6%
Probation	5	33.3%	15	27.3%
Stay charges-involuntary	1	6.7%	8	14.5%
Charges stayed			7	12.7%
Charges withdrawn/dismissed			2	3.6%
Multiple	2	13.3%	11	20.0%
WOC-unfit	2	13.3%	6	10.9%
WOC-ngri			1	1.8%
Not guilty-discharge	1	6.7%	1	1.8%
Total Cases	15	100.0%	55	100.0%

Percentages sum to more than 100% because more than one category may apply in any single case.

Table 12b

Disposition of subjects charged with minor offences by sex

Disposition	Sex			
	Male		Female	
Other	3	13.6%	8	9.4%
FPC-outpatient care			2	2.4%
Community outpatient	1	4.5%	2	2.4%
Psychiatric hospital			12	14.1%
Return FPI-further assessment	1	4.5%	5	5.9%
Custodial setting	6	27.3%	9	10.6%
Bail	2	9.1%	1	1.2%
Probation	2	9.1%	16	18.8%
Stay charges-involuntary	6	27.3%	35	41.2%
Charges stayed	1	4.5%	11	12.9%
Charges withdrawn/dismissed	1	4.5%	2	2.4%
Multiple	3	13.6%	22	25.9%
WOC-unfit	2	9.1%	2	2.4%
WOC-ngri			1	1.2%
Not guilty-discharge			1	1.2%
Total Cases	22	100.0%	85	100.0%

Percentages sum to more than 100% because more than one category may apply in any single case.

dispositional recommendations. The female and male subjects differed significantly with respect to whether they were psychiatrically assessed while in jail awaiting trial and with respect to discharge status. They also differed considerably in terms of the ultimate disposition of the criminal charges pending at the time of admission to FPI, regardless of the seriousness of those charges.

Approximately equal proportions of the female and male subjects were subsequently readmitted to FPI (26.6% and 25%, respectively). Among these 47 female and 12 male subjects, the mean number of subsequent readmissions was also very similar (1.72 and 1.67, respectively). Nine women (5.3%) and one man (2.1%) had been admitted to FPI prior to their first remand admission for the primary purpose of assessing fitness to stand trial. In order to clarify the longitudinal careers of some subjects, and particularly the use of the facilities at FPI as an adjunct to correctional facilities in the management of mentally disordered female offenders, several brief case studies will be presented.

Case Studies

One of the subjects with the greatest number of admissions to FPI over the course of the study period was a single white 47 year old (at the time of the first admission) woman living alone at a regular address. At the time of her first FPI admission she had been charged with a serious assault against a police officer and with mischief. She had been remanded to FPI for the primary purpose of

assessing fitness to stand trial, and was diagnosed with a mood disorder, but during her 23 day stay at FPI her status became that of an informal patient under the BC *Mental Health Act* and the Crown entered a stay of proceedings with respect to the charges. The second admission occurred approximately two months later following new charges of serious assault against two police officers (she had thrown cans of soups at them) and disturbing the peace. She had been remanded for a fitness assessment and was diagnosed with schizophrenia. Following a 14 day stay she was returned to court with the recommendation that she be found unfit to stand trial. The next day she was readmitted to FPI under a Warrant of Committal following a court finding of unfitness to stand trial. Following a stay of 184 days she was returned to court as fit to stand trial whereupon the charges against her were stayed by the Crown. Nearly two years passed before she was again admitted to FPI for a fitness assessment following a charge of common assault against a stranger whom she had struck with an umbrella. She was again diagnosed with schizophrenia and following a stay of 27 days she was returned to court with the recommendation that she be found unfit to stand trial. The same day she was readmitted to FPI under a Warrant of Committal following a court finding of unfitness to stand trial. Following a stay of 146 days she was returned to court as fit to stand trial whereupon she received a probationary sentence. Exactly three months later she was

admitted to FPI for a fitness assessment following charges of common assault against an unknown victim, theft, and breach of probation. She was again diagnosed with schizophrenia but this time following a 29 day stay she was returned to court with the recommendation that she be found fit to stand trial. Again she received a probationary sentence. Less than four months later she was remanded to FPI for a fitness assessment following charges of common assault against a stranger and breach of probation. She was again diagnosed with schizophrenia and following a change in her legal status to that of an informal patient under the BC *Mental Health Act*, the Crown entered a stay of proceedings with respect to the charges against her. She spent 309 days at FPI before being released into her own care.

The second example of the longitudinal forensic career of a female subject involves a single white female who had been living alone at a hotel who was admitted to FPI for the first time at age 31. At that time she had been charged with a serious assault against a police officer. She was remanded to FPI for a fitness assessment and diagnosed with schizophrenia. Following a stay of 8 days she was returned to court with the recommendation that she be found unfit to stand trial. The same day she was readmitted to FPI under a Warrant of Committal following a court finding of unfitness to stand trial. Following a stay of 106 days, during which time her diagnosis of schizophrenia was confirmed, she was returned to court as fit to stand trial but the Crown then

entered a stay of proceedings with respect to the charge and she was hospitalized as an involuntary patient under the provisions of the BC *Mental Health Act*. The woman's third admission to FPI came over six years later following two charges of disturbing the peace. She was remanded to FPI for a fitness assessment and her diagnosis remained schizophrenia. She was returned to court with the recommendation that she be found unfit to stand trial following a stay of 28 days. The following day she was readmitted to FPI under a Warrant of Committal having been found unfit to stand trial. Following a stay of 48 days she was returned to court as fit to stand trial but her records contained no indication as to how the charges were disposed. The final admission occurred over a year later following charges of break and enter and mischief. During her 28 day stay she was diagnosed with a mood disorder and returned to court with the recommendation that she be found fit to stand trial. Again, the final disposition of the charges was unknown.

One of the longest male forensic careers was that of a single white male who was 16 years old at the time of his first admission to FPI and who had been living at no fixed address when he was charged with three counts of break and enter and one count of possession of stolen property. He was remanded to FPI for a fitness assessment, was diagnosed with schizophrenia and following a stay of 33 days was returned to court with the recommendation that he be found

fit to stand trial. Just over two weeks later he was again remanded to FPI for a fitness assessment and following a stay of 18 days, during which time the diagnosis of schizophrenia was confirmed and two separate diagnoses of non-dependent drug use were added, he was returned to court with the recommendation that he be found fit to stand trial. Two days later he was remanded to FPI for a presentence assessment. Following a stay of 21 days, during which time his diagnoses remained unchanged, he was returned to court whereupon he received a custodial sentence. Just over two years later he was remanded to FPI for a fitness assessment after having been charged with two counts of sexual assault (rape) against two strangers. Following a stay of 26 days, during which time his diagnosis was schizophrenia only, he was returned to court with the recommendation that he be found unfit to stand trial. The same day he was readmitted to FPI under a Warrant of Committal having been found unfit to stand trial by the court. During this 113 day stay the diagnoses of non-dependent drug use and mixed personality disorder were added to the schizophrenia diagnosis. This final admission ended with the man being returned to court as fit to stand trial but the final disposition of the charges was unknown.

The second example of an extended male forensic career involved a separated black male who was 22 years old at the time of his first FPI admission and who had been living alone at a hotel when he was charged with setting fires. He

had been remanded to FPI for an assessment of issues other than fitness to stand trial and diagnosed with schizophrenia. He was returned to court 29 days later whereupon he was granted bail and went to live in a rooming house. Nine days later he was readmitted to FPI for a fitness assessment following an additional charge of common assault against a stranger whom he had struck with an umbrella and then began to kick. Following a stay of 21 days, during which time his diagnosis of schizophrenia was confirmed, he was returned to court with the recommendation that he be found fit to stand trial whereupon he was again granted bail. This man's third admission to FPI occurred almost three months later at which time he was remanded for a presentence assessment. Following a stay of 34 days he was returned to court retaining the diagnosis of schizophrenia. On the same day he was readmitted to FPI for an overnight stay and then returned to court whereupon he was found not guilty by reason of insanity and transported to the hospital at the Lower Mainland Regional Correctional Centre (Oakalla) to await transfer to FPI. Almost three months later he was admitted to FPI under a Warrant of Committal (NGRI). This final admission lasted 99 days, during which time he retained the diagnosis of schizophrenia, and ended with the rescindment of the Order in Council and his deportation back to his native Tanzania.

The first example of the use of FPI as an adjunct to the corrections system in the management of mentally

disordered offenders involves a single white female who was 38 years old at the time of her first FPI admission. She was certified under the BC *Mental Health Act* and then admitted to FPI as a temporary absence from Lakeside Correctional Centre for Women where she was serving a sentence for breach of a court order. During her 75 day stay at FPI she was diagnosed as having a mood disorder and then released into her own care having completed her sentence while in custody at FPI. At the time of her second admission she was living at no fixed address and had been charged with disturbing the peace and breach of a court order. She was remanded for a fitness assessment and was diagnosed with schizophrenia and non-dependent drug use. Following a stay of 16 days she was returned to court with the recommendation that she be found fit to stand trial whereupon she received a custodial sentence. Two months later she was transferred to FPI as a temporary absence from Lakeside where she had been serving a sentence for the above offences plus intoxication in a public place. Following a stay of 63 days, during which time she was diagnosed with a mood disorder, she was returned to the provincial correctional facility. Her fourth admission occurred nine months later following a charge of breach of a court order. She had been living alone at a hotel and was remanded to FPI for a fitness assessment. Following a stay of 25 days, during which time she was again diagnosed with a mood disorder, she was returned to court with the recommendation

that she be found fit to stand trial whereupon she received a custodial sentence. Just 16 days later she was transferred to FPI as a temporary absence from Lakeside. Following a stay of 21 days she was returned to the correctional facility with a diagnosis of a mood disorder. Nine months later she was transferred to FPI as a temporary absence from Lakeside where she had been serving a sentence following conviction for disturbing the peace and breach of a court order. Following a stay of 22 days, during which time she was diagnosed with a mood disorder and with alcohol dependence, she was discharged from FPI as an involuntary patient. Fourteen months later she was admitted to FPI as a temporary absence from Lakeside where she had been serving a sentence following conviction on charges of theft and intoxication in a public place (offences which occurred while she was living with her common-law husband). She spent 26 days in FPI, during which time her diagnosis reverted to a mood disorder only, and was then returned to the correctional facility.

The second example of the use of FPI as an adjunct to the corrections system in the management of mentally disordered offenders involves a separated native female who was 25 years old at the time of her first admission to FPI. She had been living at no fixed address when she was charged with theft and driving while her blood-alcohol level was over .08. Following these charges she was remanded to FPI for a fitness assessment and received a diagnoses of alcohol

dependence. Nineteen days following this admission she escaped custody and was discharged as an unauthorized absence. Two months later she was admitted to FPI as a temporary absence from Lakeside. During this admission she received a diagnosis of alcohol induced psychosis. Following a stay of 48 days she was returned to the correctional facility. Just over three months later she was admitted to FPI for a fitness assessment following two charges of serious assault against strangers and possession of an offensive weapon (a knife). During this admission she was diagnosed with an alcohol induced psychosis, alcohol dependence and mental retardation. Following a stay of 27 days she was returned to court with the recommendation that she be found fit to stand trial whereupon she received a custodial sentence. Eight months later she was transferred to FPI as a temporary absence from Lakeside having been convicted on one count of serious assault and the weapons offense. During this admission her diagnosis of alcohol induced psychosis, alcohol dependence and mental retardation was confirmed. Following a stay of 22 days she was returned to the correctional facility. Just two months later she was returned to FPI from Lakeside on a temporary absence pass. During this 40 day admission she received a diagnosis of schizophrenia and schizotypal personality disorder and was then returned to the correctional facility.

The only male admitted to FPI as a temporary absence from a correctional facility during the course of the study

period was a single male who was 26 years old at the time of his admission who had been living at no fixed address when he was charged with two counts of theft and driving while under suspension. He remained in the custody of FPI for 43 days, during which time he received a diagnosis of schizophrenia, before being returned to the correctional facility.

In summary, the facilities of the Forensic Psychiatric Institute may be used for a variety of purposes and at various stages of court proceedings for both female and male offenders who suffer or who are suspected to suffer from mental illness, and the breadth of FPI's mandate can result in multiple admissions to FPI for any single offender. However, its use as an adjunct to correctional facilities in the management of mentally disordered offenders is far more common in relation to female offenders than male offenders suggesting that the resources for managing mental illness may be lacking in female correctional facilities.

CHAPTER 4

DISCUSSION

On the basis of the findings of this thesis, ideologically-based conceptions of female deviance, both criminality and madness, appear to influence the forms of control deemed preferable in the management of such deviance. More particularly, the dovetailing of sexist conceptions of female criminality and of female mental health, as well as the implications of these conceptions, suggest the potential importance of gender in the forensic psychiatric decision making process. The role of gender in this process was primarily explored in the present study using information collected through a review of the forensic records of 170 women and 48 men. The detailed description and comparison of statistical information relating to these female and male subjects during their first admission to the Forensic Psychiatric Institute under remand status for the purpose of assessing fitness to stand trial was supplemented by an examination of the longitudinal forensic careers of selected subjects through the presentation of several brief case studies.

The rates of referral to the Forensic Psychiatric Institute for all females and males criminally charged in British Columbia during the period of the study were not available. However, research evidence suggests that a greater proportion of female than male accused are referred

for forensic psychiatric assessment (see Menzies, Chunn & Webster, 1992).

Prior to direct discussion of the results, it is useful to consider some qualitative material which should assist in establishing the context for the discussion of the quantitative results. As well, the illustrations will serve as exemplars for some of the main theoretical perspectives discussed at the beginning of the thesis.

Illustrations of the Forensic Psychiatric Processing of Women

Several of the themes identified at the outset may be clarified by this qualitative information extracted during the review of the forensic records of the female subjects. First, the subtle importance of compliance with the examining psychiatrist, and particularly the importance of compliance within gender role norms, is illustrated in the following direct quotes. In the first example, a doctor who spoke to one woman prior to her arrest submitted a consultation report to FPI which became a permanent part of her forensic record. Under the heading of Mental Status Exam the doctor writes the following:

> "Shows [the patient] to be alternating [sic] smiling and hostile and resistant to the interview. During the interview, while I was alone with her [the patient] was also verbally abusive of me in a variety of different ways. She was paranoid in a generalized way rambling about rights against women being broken and that what happened to her was a feminist issue that she needed someone who understood the lot of women and repeatedly urged that I should be watching the movie 'Nuts' which she somehow related to. Her speech was disorganized with flight of ideas and her mood was inappropriate to

> the situation. She also told me this was a legal issue."

Thus were this woman's legitimate, and relevant, concerns with having become involved with the control networks of both the criminal justice system and the mental health system characterized as evidence of her mental illness and effectively dismissed from further consideration.

Evidence of compliance with gender role norms was accorded special recognition in the assessment of a woman who was admitted to FPI as a temporary absence from a provincial correctional facility where she had been serving a sentence for the second degree murder of her spouse. Within the initial assessment under the heading of Current Mental Status the examining psychiatrist writes:

> "Possibility of average intelligence, her background education is limited, life skills limited, her understanding of basic concepts is average, employment skills are average, *she organized her own household well.*" (emphasis added)

The implication is that, while not worthy of recognition as a life skill, the ability to manage a household, according to gender role expectations, was this woman's one redeeming quality.

The preference for managing female deviance within the 'soft' end of the social control network is revealed in the police report written with respect to the case of the first woman discussed above. Following discussion with two doctors at a suburban general hospital who had spoken with the accused, the police officer notes:

> "Both agreed that [the patient] had severe emotional problems and should be committed, however, subsequent checks at various lower mainland hospitals revealed that there were no psychiatric beds available anywhere. Having no alternative due to the fact that the accused was a danger not only to herself but others, the accused was arrested and returned to cells where Cst. ... proceeded to fingerprint and photograph [the patient]."

This subject was subsequently charged with common assault causing bodily harm, possession of a weapon, and mischief. However, despite the commission of these relatively serious offences, the initial response of the police was to try to dispose of this case through the less formal means provided by mental health legislation. Only the realities of health care availability led to legal charges being brought against this woman. During her subsequent admission to FPI for the assessment of fitness to stand trial she was assessed over a 59 day period before being returned to court with the recommendation that she be found fit to stand trial. However, on the same day she was readmitted to FPI under a Warrant of Committal following a court finding of unfitness to stand trial. She spent at least 53 days under this status and was in fact still in custody at the close of the study period. Thus the charges which were reluctantly brought as a result of limited health care resources had not been formally dealt with before the courts after more than 100 days and instead she remained in the less formal legal limbo of custody/treatment within the authority of the forensic psychiatric system.

The tendency to view female deviance, and particularly the failure to comply with gender norms such as feminine passivity, as evidence of mental unbalance is illustrated in the case of a woman who had, according to the police report, been experiencing severe marital strife, with each partner employing physical violence against the other, prompting numerous police interventions at the request of disturbed neighbors. On the occasion of her arrest she had been beaten by her husband and as a result was in a state of extreme distress when police arrived. She alone was arrested and charged with two counts of disturbing the peace, and one count each of threatening and obstructing justice. On admission to FPI for an assessment of her fitness to stand trial she had, according to the nursing assessment, "numerous bruises on body, swelling in left temporal region of skull and a black left eye sustained during a beating from her husband." The nursing assessment goes on to report that the subject had "admitted self into ... General Hospital on advice of RCMP for 3 days in July of this year" and then quotes the subject explaining:

> "I was having marital problems with my husband and I needed to get away for awhile. The psychiatrist I saw recommended I attend weekly therapy sessions but I never did, my husband is the one who needs help for his violence, not me."

This woman was held in custody for 27 days, and acquired a diagnosis of mixed personality disorder, before being returned to court with the recommendation that she be found fit to stand trial. No information was available as

to what became of her husband. The implication is, nevertheless, clear. Her violent behavior in the face of an abusive situation was taken, even by the police, as evidence of an individual pathology requiring the intervention of psychiatric treatment.

As outlined earlier, police, court and forensic actors exercise considerable discretion in the management of offenders. Clear illustration of this point is found in the case of one woman who was admitted to FPI for a fitness assessment following a charge of fraudulently obtaining food. Ten days following her admission she became an involuntary patient -- simultaneous to the entry of a stay of proceedings by the crown -- whereupon she remained in custody for 134 days before being discharged into her own care. The following was written by the attending psychiatrist in a letter to a provincial mental health centre requesting follow-up care for the woman:

> "[the patient] was admitted to the Institute after being remanded for psychiatric assessment following her arrest on charges of food fraud. These relatively minor charges were 'used' [sic] in order to obtain medical treatment for [the patient] who for the past 2 years was resistant to accepting treatment for her longstanding psychotic illness."

The report of the psychiatric social worker notes that the woman's brother:

> "had heard that his sister was subsisting on cat food and despite repeated attempts to pressure authorities to commit his sister for treatment, he was unsuccessful until minor false pretence [sic] charges were revived in order to have [her] remanded for psychiatric assessment."

Similarly, another patient was admitted to FPI for a fitness assessment, but after 21 days became an involuntary patient (whereupon a stay of proceedings was entered by the crown), despite the previous refusal of her own doctors to certify her. She spent 70 days under this status before being released into her own care. The following was written by the attending psychiatrist in a letter to the Riverview Review Panel:

> "[the patient] is a 43 year old woman who was admitted to the Forensic Psychiatric Institute for psychiatric observation on ..., on a charge of breaking and entering a residence and stealing a bicycle. I was personally involved in assessing her in the jail in ..., B.C. and am aware that the legal charges were not considered serious and really arose out of desperation on the part of the RCMP who were aware of many recent acts of disturbed behavior on the part of [the patient], such that they felt the necessity to use legal means to secure psychiatric treatment for her. Consequently the legal charges were stayed once [the patient] was certified under the Mental Health Act here at the Forensic Psychiatric Institute."

Thus the police, the prosecution, and the responsible psychiatrist may at their discretion make use of the *Criminal Code* provisions governing mentally disordered defendants to by-pass the evidentiary requirements of civil commitment, secure immediate custody and treatment of such defendants, and at the same time provide the opportunity for the gathering of information necessary for initiation of civil commitment proceedings.

The role of the police in the management of forensic subjects cannot be underestimated (see Menzies, 1987). While the Crown Counsel is often the official referral

source, this decision is, of course, based largely upon the police report which may contain evidence of the accused's behavior at the time of the offence and at the time of arrest, information concerning prior police contacts, information concerning psychiatric history, and recommendations regarding bail. For example, it was not unusual to find comments such as "definitely mentally ill" within the police report and as Menzies (1987) demonstrates such comments often follow the subject, and form the basis for elaboration, throughout the forensic assessment process.

At this point it is important to remind the reader that while the discretionary practices of the police, the courts, and forensic psychiatric actors are equally available for use in the management of both male and female deviance, of the 71 male admissions studied only one resulted in the man becoming an involuntary patient. In contrast 61 of the 323 female admissions studied ended in the civil commitment of the woman involved. This situation suggests that patterns of discretionary decision-making are discernable and those patterns represent the dual treatment of female and male offenders.

The illustrative material presented above provides impressionistic support for the importance of compliance with gender role norms, the tendency to view female criminal deviance as evidence of mental unbalance, the preference for the use of less formal means of control in the management of female deviance, the role of discretionary practices in the

processing of offenders, and the dual treatment of female and male offenders. This contextual background serves to highlight the quantitative findings to which the discussion will now turn.

Consideration of the Quantitative Findings

A number of the characteristics of female offenders remanded for psychiatric assessment described by other researchers in other jurisdictions are evident in the jurisdiction of British Columbia. For example, the characteristics of the female subjects of this study are quite similar in terms of age, ethnicity, employment status, marital status, current criminal charge(s), diagnosis, findings of unfitness, and custodial dispositions to those found by Menzies, Chunn and Webster (1992) in their study of females admitted to the METFORS clinic in Toronto. Differences between the findings of the present study and the findings of Menzies et al. (1992) in relation to female forensic patients include the greater stability of living arrangements in childhood, the larger proportion of women with a history of at least one psychiatric hospitalization, the smaller proportion of women with previous criminal convictions, and the larger proportion of women certified under mental health legislation, respectively.

With respect to demographic and social characteristics the female subjects of this study are also quite similar to those women studied by Hodgins, Hebert and Baraldi (1986) in Quebec. Differences between the findings of the present

study and those of Hodgins et al. (such as the greater frequency of previous arrest record and the smaller proportion of serious or violent charges in the present study) may be explained with reference to differences in the composition of the two samples. Hodgins et al. (1986) looked at a relatively small sample of women who had already passed through the assessment stage of the criminal proceeding and had been adjudicated unfit to stand trial or not guilty by reason of insanity.

The socioeconomic characteristics of the female subjects of this study are also consistent with the findings of Rosner, Wiederlight and Wieczorek (1985) and Harmon et al. (1983) in New York State, and Baridon and Rosner (1981) in Washington, DC.

The major differences in the characteristics of the females and males studied in this thesis, such as the greater prevalence of criminal history and alcohol and drug abuse among the male subjects, were not found in the comparison of females and males admitted to the METFORS clinic in Toronto (Menzies et al., 1992). These differences may help to explain why discrepancies in the ultimate disposition of the cases observed in this study were not found in the METFORS research.

The Dual Treatment of Females and Males within the Forensic Psychiatric System

With respect to many demographic, social and psychiatric characteristics as well offence profile and

diagnosis, the females and males admitted to FPI were generally similar. Nevertheless, there were substantial differences in the disposition of charges against the female and the male subjects, regardless of the seriousness of the charges pending. These findings suggest that in fact women and men are processed differently by the forensic psychiatric system with the women tending to be perceived as "mad" and diverted from the authority of the criminal justice system and into the authority of the mental health system, and with the men tending to be perceived as "bad" and returned to the courts for formal disposition of the charges, which in many cases meant a custodial sentence. These findings provide support for the dual treatment argument addressed by Allen (1987).

In contrast, no evidence was found to support the 'functional equivalence' thesis discussed by Smart (1976). In this setting, both the female and the male subjects displayed psychiatrically classifiable symptoms as well as criminal conduct. There were no systematic differences in the seriousness of the criminal charges which prompted the admission to FPI or in the seriousness of the diagnosis rendered at the time of discharge from the institution. The nature of the violent offences also did not differ in any dramatic way. For both the female and the male subjects, the most frequent victims of their violent behavior were adult strangers. Among the other cases, both the females and the males had victimized family members and children.

The finding that within the domestic setting the men tended to victimize their own parents and the women tended to victimize their own children may be explained with reference to the physical size and strength of the offender as well as to the differences in the subjects' living arrangements at the time of the offence. The tendency among the male subjects to victimize the children of others, rather than their own children, cannot reasonably be interpreted as evidence of relative "sanity", while the tendency among the female subjects to victimize their own children is considered evidence of "madness". Thus, in this setting the nature of female criminality does not differ substantially from the nature of male criminality regardless of the apparent inclination to pathologize the female offender.

Instead, the findings provide support for the proposal that agencies of social control, from the formal to the informal, tend to view and manage female deviance within the 'soft end' of the social control network (Cohen, 1985) and conversely, that male deviance tends to be viewed and managed at the 'hard end' of societal controls. Perceived differences in the dangerousness of the mentally disordered female and male offender do not explain this dual treatment. Regardless of the seriousness of the offence, the cases of the female subjects were more likely than the cases of the male subjects to be disposed of informally through the entry of a stay of proceedings by the Crown and the involuntary committal of the accused. In addition, while less formal

than a criminal disposition, the requirements of an involuntary admission may still involve the consideration of the needs of society for protection from the behavior of the accused.

The finding that female and male subjects within the forensic psychiatric system are subjected to dual treatment should not, however, be interpreted, as Allen (1987) interprets her similar finding, as evidence of leniency toward female offenders. As Verdun-Jones (1981) points out an accused person who is committed as an involuntary patient is prevented from returning to court for the determination of fitness, and more significantly is denied the opportunity to present a defense to the charges. Clearly such "involuntary diversion" (Verdun-Jones, 1981, p. 383) may be detrimental to the accused's best interests. Raetzen (1977) argues

> "In many instances a finding of guilt will result in a suspended sentence, conditional discharge or a short period of incarceration. All of these dispositions may be regarded by the individual as being less severe than the incarceration in a mental health facility which may occur upon diversion from the criminal justice system. The individual can at least rest assured that the criminal justice system disposition has a determinate quality to it, whereas the psychiatric diversion alternative may be indeterminate in nature. Further, there is no guarantee that the promise of care and treatment held out by the diversion alternative will in reality be fulfilled because of the inadequacy of the diversion alternative, or lack of desire of the individual to participate in that alternative." (pp. 132)

In this context, it is significant to note that involuntarily committed patients are routinely denied the

right to refuse treatment (Verdun-Jones, 1988), a right which is in no way surrendered upon admission to a correctional facility.

Thus the agents of the criminal justice system and the forensic psychiatric system can not be seen to be acting out of a sense of "chivalry" in their "lenient" (Pollak, 1950) treatment of female defendants, but rather the findings are indicative of the state's acceptance of the notion that female criminality is evidence of mental unbalance and its concurrent preference for managing female deviance within the less formal setting of the psychiatric hospital, with the limited rights attached to custody in such a setting.

Similarly, the use of the facilities of FPI as an adjunct to provincial correctional facilities for women, rather than providing for the treatment of emotional and behavioral problems within the correctional setting, is indicative of the preference for managing such problems within a hospital setting, where the subject, because of the legal means by which temporary absences are accomplished, can be treated without her consent.

Such a choice essentially and invariably denies the subject of any claim to rationality and renders her a powerless, pitiable victim of circumstances who acts in isolation of the social realities and agents governing her life. Thus her actions, right or wrong, are stripped of all social significance and she can be dismissed as an aberration.

Given the insidious nature of the ideologies which inform conceptions of deviant female behavior, it is unlikely that improvements to the *Criminal Code* alone, while undeniably necessary, will do much to halt the use of the forensic psychiatric system as a convenient point of diversion of females out of the authority of the criminal justice system and into the authority of the mental health system. As argued here, the discretionary decisions which result in the dual treatment of female and male offenders are based on pervasive and deeply rooted attitudes about the roles of women and men in our society and these attitudes are highly resistant to change. Practically speaking, what can be done is to govern more closely the interaction and relationship of prosecutorial and forensic psychiatric agents.

With respect to fitness assessment remands the most salient revisions to the *Criminal Code* involve the provision for outpatient assessments, limitations on the length of an assessment order, and restrictions on the prosecutorial and judicial use of fitness assessments. Specifically, fitness assessments are now generally limited to 5 days (up to a maximum of 60 days in exceptional cases), and may be conducted on an outpatient basis. In the case of summary proceedings, the accused must consent to an initial assessment and only on the basis of the results of this assessment (i.e., the physician reports that there is sufficient reason for the person to be remanded) may the

court order the accused remanded for an assessment of fitness to stand trial.

In light of the finding that the majority of remanded subjects were returned to court as fit to stand trial (following an average stay of between 22 and 24 days for the female and male subjects, respectively), the limitation placed on the length of a routine assessment order represents a definite improvement over the previous maximum (under ordinary circumstances) of 30 days. The shortened assessment period may, however, result in more frequent findings of unfitness, as some defendants who previously may have become fit over the period of the assessment are now likely to be returned to court with the recommendation that they be found unfit.

Future Research

Against the descriptive base provided by this research, several possibilities for further study are apparent. First, this data set provides a baseline for the comparison of forensic psychiatric decisions prior to and following revisions to the *Criminal Code* legislation relating to mentally disordered offenders. Second, the work of Anasseril, Harris, and Husain (1981) who looked at the characteristics of young versus mid-life women who were remanded for forensic assessment in Missouri could be replicated in the British Columbian context in order to increase awareness of the specific needs and concerns of young and mid-life female offenders. Third, a systematic

content analysis of forensic records would further clarify the ways in which gender role norms enter and influence the forensic psychiatric process. Finally, a follow-up of the core group of offenders remanded for the assessment of fitness with respect to subsequent psychiatric and criminal justice contacts would provide greater insight into the medico-legal careers of these subjects, as well as the nature and cost of society's response to these 'troublesome' citizens.

REFERENCES

Allen, H. (1987). Justice unbalanced: Gender, psychiatry and judicial decisions. Milton Keynes, UK: Open University Press.

Anasseril, D., Harris, P., & Husain, A. (1981). Differences between midlife female offenders and those younger than 40. American Journal of Psychiatry, 138(9), 1225-1228.

Baridon, P. & Rosner, K. (1981). Characteristics of women forensic patients in a federal hospital. Hospital & Community Psychiatry, 32(1), 50-53.

Broverman, I., Broverman, D., Clarkson, F., Rosenkrantz, P., & Vogel, S. (1970). Sex role stereotypes and clinical judgements of mental health. Journal of Consulting and Clinical Psychology, 34, 32-40.

Chesler, P. (1972). Women and madness. Garden City, NY: Doubleday.

Chunn, D.E. & Menzies, R.J. (1990). Gender madness and crime: The reproduction of patriarchal and class relations in a psychiatric court clinic. The Journal of Human Justice, 1(2), 33-54.

Cohen, S. (1985). Visions of social control: Crime, punishment and classification. New York: Polity Press.

Conrad, P. & Schneider, J.W. (1980). Deviance and medicalization: From badness to sickness. St. Louis: C.V. Mosby Company.

Dalton, K. (1961). Menstruation and crime. British Medical Journal, December 30, 1752-1753.

Ehrenreich, B. & English, D. (1978). For her own good. Garden City, NY: Anchor Press Doubleday.

Freud, S. (1956) Some psychological consequences of the anatomical distinction between the sexes. Collected Papers, Vol. 5. London: Hogarth.

Gavigan, S. (1982). Women's crime and feminist critiques: A review of the literature, Canadian Criminology Forum, 5(1), 40-53.

Hagan, J., Simpson, J., & Gillis, A. (1979). The sexual stratification of social control: A gender-based perspective on crime and delinquency. British Journal of Sociology, 30(1), 25-38.

Harmon, R., Rosner, R., Wiederlight, M., & Potter, L. (1983). Analysis of demographic variables of women evaluated in a forensic psychiatry clinic in 1980 and 1981. Journal of Forensic Sciences, 28(3), 560-571.

Heidensohn, F. (1985). Women and crime. London: Macmillan.

Hodgins, S. (1983). A follow-up study of persons found incompetent to stand trial and/or not guilty by reason of insanity in Quebec. International Journal of Law and Psychiatry, 6, 399-411.

Hodgins, S., Hebert, J., & Baraldi, R. (1986). Women declared insane: A follow-up study. International Journal of Law and Psychiatry, 8, 203-216.

Horney, J. (1978). Menstrual cycles and criminal responsibility. Law and Human Behavior, 2(1), 25-36.

Husain, A., Anasseril, D., & Harris, P. (1983). A study of young-age and mid-life homicidal women admitted to a psychiatric hospital for pre-trial evaluation. Canadian Journal of Psychiatry, 28, 109-112.

Jung, C. (1928). Contributions to analytical psychology. New York: Harcourt, Brace.

Lindsay, P. (1977). Fitness to stand trial in Canada: An overview in light of the recommendations of the Law Reform Commission of Canada. Criminal Law Quarterly, 19, 303-348.

Lombroso, C. (1895). The female offender. New York: Appleton.

Menzies, R.J. (1987). Cycles of control: The transcarceral careers of forensic patients, International Journal of Law and Psychiatry, 10, 233-249.

Menzies, R.J. (1987). Psychiatrists in blue: Police apprehension of mental disorder and dangerousness, Criminology, 25(3), 429-453.

Menzies, R.J., Chunn, D.E. & Webster, C.D. (1992). Female follies: The forensic psychiatric assessment of women defendants, International Journal of Law and Psychiatry, 15, 179-193.

Menzies, R. & Webster, C. (1987). Where they go and what they do: The longitudinal careers of forensic patients in the medicolegal complex. Canadian Journal of Criminology, 29, 275-293.

Mizruchi, E. (1983). Regulating society: Marginality and social control in historical perspective. New York: The Free Press.

Morris, A. & Gelsthorpe, L. (1981). Women and crime. Cambridge, UK: University of Cambridge Institute of Criminology.

Penfold, P.S. & Walker, G.A. (1983). Women and the psychiatric paradox. Montreal: Eden Press.

Pollak, O. (1950). The criminality of women. Westport, CT: Greenwood Press.

Raetzen, M.S. (1977). Diversion of the potentially mentally disordered offender: A "Rose by any other Name", University of British Columbia Law Review, 11, 119-143.

Rafter, N. (1983). Chastizing the unchaste: Social control functions of a women's reformatory, 1894-1931. In S. Cohen & A. Scull (Eds.), Social control and the state: Historical and comparative essays. (pp. 288-311). Oxford: Martin Robertson.

Rickel, N. (1971). The angry woman syndrome. Archives of General Psychiatry, 24, 560-571.

Rosenblatt, E. & Greenland, C. (1974). Female crimes of violence. Canadian Journal of Criminology, 16(2), 173-180.

Rosner, R., Wiederlight, M., & Wieczorek, R. (1985). Forensic psychiatric evaluations of women accused of felonies: A three-year descriptive study. Journal of Forensic Sciences, 30(3), 721-729.

Rothman, D. (1971). The discovery of the asylum: Social order and disorder in the new republic. Boston: Little, Brown.

Scull, A. (1979). Museums of madness: The social organization of insanity in nineteenth century England. London: Allen Lane.

Showalter, E. (1985). The female malady: Women, madness, and English culture. Toronto: Random House.

Smart, C. (1976). Women, crime and criminology: A feminist critique. Boston: Routledge & Kegan Paul.

Smart, C. (1977). Criminological theory: Its ideology and implications concerning women. British Journal of Sociology, 28(1), 89-100.

Smart, C. & Smart, B. (Eds.) (1978). Women, sexuality and social control. Boston: Routledge & Kegan Paul.

Szasz, T. (1963). Law, liberty and psychiatry: An inquiry into the social uses of mental health practices. New York: MacMillan.

Toch, H. (1982). The disturbed disruptive inmate: Where does the bus stop? The Journal of Psychiatry and Law, Fall, 327-349.

Verdun-Jones, S. (1981). The doctrine of fitness to stand trial in Canada. International Journal of Law and Psychiatry, 4, 363-389.

Verdun-Jones, S. (1988). The right to refuse treatment: Recent developments in Canadian jurisprudence, International Journal of Law and Psychiatry, 11, 51-60.

Weisheit, R. & Mahan, S. (1988). Women, crime, and criminal justice. Cincinnati: Anderson Publishing Co.

APPENDIX I

CODING MANUAL

1. Identifier Code (1-3)
   A three digit code assigned to all subjects and cross-referenced to the patient's FPI number on a separate index. A second index will cross-reference the patient's identifier code with her name, aliases, and date of birth.

2. Admission Number (4)

3. Record Number 1 (5)

<u>Section A</u> <u>Demographic Information</u>

4. Date of Birth (6-11)
   Code as year, month, day.

5. Sex (12)
   0=Male
   1=Female

6. Religion (13-16)

1=Protestant	6=Islamic Muslim
2=Catholic	7=Hindu
3=Jewish	8=Buddhist
4=Mormon	9=Unknown/No info
5=Fundamentalist (Baptist)	0=Other

   Using the above codes, code what the patient was raised as (13), as well as what she is on the present admission (14). If the patient has no religious affiliation, leave 13-16 blank.

   Perceived Importance (15)

1=Not important	4=Very important
2=Somewhat important	5=Most significant part of life
3=Important	9=Unknown/No info

   Outward Participation (16)

1=None	4=Membership, regular frequent involvement
2=Nominal involvement	5=Continuous involvement
3=Membership, occasional involvement	9=Unknown/No info

   The above information may be found on the data (face) sheet of the patient's chart although it should be noted that this information is provided by the patient on admission and may not be thorough or accurate. Confirm information through other sources if possible.

7. Education (17)

1=None	6=Some university
2=Elementary (1-9)	7=University degree
3=Secondary (10-13)	8=Graduate degree
4=Community college	9=Unknown/No info
5=Vocational/Tech. college	0=Other

'Community college',eg., Langara. 'Vocational/Tech. college', eg., PVI/BCIT. Code 'Secondary' only if high school has been completed.

8. Main Source of Income (18)

1=Self	5=U.I.C.
2=Spouse	6=Welfare
3=Parents	7=Pension
4=Children or other relatives	8=Other allowance
	9=Unknown/No info
	0=Other

Code the patient's source of income at the time of arrest on charges related to present admission.

9. Employment Status (19)

1=Employed full time	5=Unemployed
2=Employed part time	6=Retired
3=Occasionally or seasonally employed	7=Not applicable (housewife, student)
4=Military	9=Unknown/No info
	0=Other

Code status at time of arrest on charges related to the present admission.

10. Occupation (20)

1=None	6=Student
2=Unskilled	7=Homemaker
3=Semi skilled	8=Retired
4=Skilled	9=Unknown/No info
5=Professional/Managerial	0=Other

Code patient's most recent occupation prior to present admission.

11. Ethnic Group (21)

1=White	4=Oriental
2=Native Indian	5=Black
3=East Indian	9=Unknown/No info
	0=Other

12. Marital Status (22-27)

1=Single	4=Widowed
2=Married	5=Divorced
3=Common Law	6=Separated
	9=Unknown/No info

Code the patient's marital status at the time of arrest on charges related to the present admission. If the patient is currently married, code marital adjustment at time of arrest: (23)

1=Very good	4=Poor
2=Good	5=Very poor
3=Fair	9=Unknown/No info

If the patient was <u>ever</u> married, enter age at first marriage (24-25) and number of times married (includes common law marriages)(26-27). (If either is unknown, code '99').

13. Number of children (28-35)

Enter number of: pregnancies (28-29)
(female admissions only)
live births(30-31)
surviving children (32-33)
(i.e., alive at admission)
children in patient's custody at the time of the offence (34-35)
(a child may not be in patient's custody either because they are over the age of majority or have been removed from the home).

Code '99' if unknown

<u>Section B</u> <u>Social History</u>

1. Living Arrangements - Youth (36-39)

1=Natural parents	6=Grand parents
2=Mother	7=Multiple placements
3=Father	8=Step- w/natural parent
4=Adoptive parents	9=Unknown/No info
5=Foster parents	0=Other

Enter the living arrangement that was most significant in terms of time. 'Youth' refers to the period from birth to 18 years. If the 'multiple' category is used, use the above codes to enter the most significant (in terms of time) three placements in 37-39.

2. Living Arrangements - Prior to offence (40-41)

1=Transient	12=Boarding/group/rooming house
2=No fixed address	13=Hospital
3=Alone at hotel	14=Penal institute
4=Alone @ regular address	15=With young children
5=With spouse	16=With siblings
6=With spouse & children	17=With roommate (friends)
7=With parent(s)	9=Unknown/No info
8=With adult children	0=Other
11=With other relatives	

Code the patient's living arrangements at the time of arrest on charges related to the present admission.

3. Sexual Abuse - Youth (42-43)

1=Yes	3=Suspected
2=No	9=Unknown/No info

Code whether the patient was sexually abused as a youth (i.e., under 18 years of age). Enter '2' only if the information available is explicit, otherwise enter '9'. If '1' is entered, code who was the perpetrator of the abuse.

1=Father	6=Trusted adult
2=Mother	7=Stranger
3=Sibling	8=Step-parent
4=Other family member	9=Unknown/No info
5=Spouse	0=Other

4. Physical Abuse - Youth (44-45)

1=Yes	3=Suspected
2=No	9=Unknown/No info

Code whether the patient was physically abused as a youth (i.e., under 18 years of age). Enter '2' only if the information available is explicit, otherwise enter '9'. If '1' is entered, code who was the perpetrator of the abuse.

1=Father	6=Peer
2=Mother	7=Stranger
3=Sibling	8=Step-parent
4=Father and mother	9=Unknown/No info
5=Spouse	0=Other

5. Psychiatric Disorder Among Family Members (46-49)

1=Mental retardation	6=Personality disorders
2=Substance use disorders	7=Psychosexual disorders
3=Schizophrenic disorders	8=Multiple disorders
4=Psychotic disorders	9=Unknown/No info
5=Affective disorders	0=Other

If psychiatric disorder has been <u>diagnosed</u> in a (biological) family member, enter the appropriate diagnosis for each of the following: Mother (46), Father (47), Sibling (48), Other relative (49). If multiple disorders are present, specify in the comments section. If the diagnosis is organic brain syndrome use 'other' and comment. If there is no diagnosed disorder, leave section blank.

6. Family Criminal History (50-52)

1=Yes
2=No
9=Unknown/No info

Enter whether members of the patient's (biological) family have a criminal history. Enter '2' only if the available information is explicit, otherwise enter '9'. If '1' is entered, code the family member (51) and the type of offence (52)

1=Father	4=Other family member
2=Mother	5=Multiple members
3=Sibling	9=Unknown/No info

(if '5' is entered here specify in comments)

1=Violent/personal	3=Victimless
2=Property	4=Public Order
	0=Other

7. Family Alcohol/Drug Abuse (53-57)

0=No problem	2=Drugs
1=Alcohol	3=Both alcohol and drugs
	9=Unknown/No info

'Family' refers to any family member who shared domicile with the patient for any significant period. 'Drugs' refer to the use of controlled substances as well as the abuse of prescription or non-prescription drugs. Using the above codes, enter abuse by Mother (53), Father (54), Sibling (55), Other (56), Spouse (57).

8. Sexual Abuse - Adult (58-59)
   1=Yes 3=Suspected
   2=No 9=Unknown/No info
   Code whether the patient was sexually abused as an adult (i.e., 18 years and over). If '1' is entered code who was the perpetrator of the abuse.
   1=Father 5=Spouse
   2=Mother 6=Friend/Acquaintance
   3=Sibling 7=Stranger
   4=Other family member 9=Unknown/No info
   0=Other

9. Physical Abuse - Adult (60-61)
   1=Yes 3=Suspected
   2=No 9=Unknown/No info
   Code whether the patient was physically abused as an adult (i.e., 18 years and over). If '1' is entered code who was the perpetrator of the abuse.
   1=Father 5=Spouse
   2=Mother 6=Friend/Acquaintance
   3=Sibling 7=Stranger
   4=Other family member 9=Unknown/No info
   0=Other

<u>Section C</u> <u>Psychiatric History</u>

1. Age at first manifestation of illness (62-63)
   If unknown, enter '99'.

2. Age at first treatment of psychiatric illness (64-65)
   If unknown, enter '99'.

3. Number of admissions to <u>other</u> psychiatric <u>inpatient</u> facilities (includes Riverview) (66-67)

4. Previous outpatient care (68-70)
   1=Mental health centre
   2=Community care team (eg., group home placement)
   3=Outpatient dept./Riverview
   4=Outpatient dept./other psychiatric hospital
   5=Outpatient dept./general hospital
   6=Private therapy with a psychiatrist
   7=Private therapy with other therapist
   8=Forensic clinic
   9=Unknown/No info
   0=Other
   Enter up to three relevant categories relating to the period prior to the current offence(s).

5. Intelligence Quotient (71)

1=Superior
2=Above average
3=Below average
4=Retarded
5=Average
9=Unknown/No info

The descriptions "high-average" and "low average" should be coded as 'above average' and 'below average' respectively.

6. Number of suicide attempts (72-73)

Enter number of suicide attempts during the period since most recent (FPI) discharge to present admission. If this is a first admission, enter all known previous attempts. If no known previous attempts, enter '00' (or '0'). If known previous attempts but no information regarding number, enter '98'. If unknown, enter '99'.

7. Suicidal ideation (74)

1=Frequently
2=Occasionally
3=Seldom
4=Never
9=Unknown/No info

Enter information relating to the period covered by present admission (and recent past). Enter information provided by a mental health professional only (explicit mention or 'many' attempts).

<u>Section D</u> <u>Drug and Alcohol Use</u> (history of or current)

1. Alcohol (75)

1=No use
2=Occasional use
3=Regular use
4=Abuse
5=Addiction
9=Unknown/No info

Look for use of the above descriptive terms and enter the appropriate code. This method applies to the following 2 categories as well.

2. Controlled substances (76)

1=No use
2=Occasional use
3=Regular use
4=Abuse
5=Addiction
9=Unknown/No info

Controlled substances are those included in either the <u>Narcotic Control Act</u> or the <u>Food and Drug Act</u>.

3. Non-prescription drugs (77)
   - 1=No use
   - 2=Occasional use
   - 3=Regular use
   - 4=Abuse
   - 5=Addiction
   - 9=Unknown/No info

   Non-prescription drugs include 'over the counter' drugs such as aspirin, laxatives, codeine, etc., as well as other uncontrolled intoxicants such as glue, lysol, rubbing alcohol, etc. (Nicotine and caffeine are are not included). Generally such use is only noted if it is problematic (eg., abuse).

4. Abuse of prescribed drugs (78)
   - 1=Yes
   - 2=No
   - 9=Unknown/No info

5. Drug use at time of offence (79)
   - 1=Yes
   - 2=No
   - 9=Unknown/No info

   Specifically, this refers to use of controlled substances or abuse of non-prescription or prescription drugs at the time the offence related to the current admission occurred.

6. Alcohol use at time of offence (80)
   - 1=Yes
   - 2=No
   - 9=Unknown/No info

   Use of alcohol at the time the offence related to the current admission occurred.

Section E Psychiatric Referral and Assessment Information

1. Identifier Code (1-3)

2. Admission Number (4)

3. Record Number 2 (5)

4. Referral source (6)
   - 1=Crown Counsel
   - 2=Defence
   - 3=Judge/Court
   - 4=Medical Officer
   - 5=N/A
   - 6=Probation Officer
   - 7=Self
   - 8=Riverview Hospital
   - 9=Unknown/No info
   - 0=Other

   This information is found on the referral sheet in the legal file. Code 'N/A' if admission is a 'continuation' of a previous referral (ie., subsequent admission related to original criminal charges). Code '8' if admission is a March 1979 transfer from Riverview Hospital.

5. Psychiatric opinion(s) requested (7)
   1=Existence of mental illness
     (including certifiability)
   2=Fitness to stand trial
   3=Mental state at time of offence
   4=Treatment needs
   5=Social assessment
   6=Personality assessment
   7=Pre-sentence report/recommendations
   8=All of the above
   9=Unknown
   0=Other
   This information is found on the referral sheet in the legal file. Enter information only for remand and T/A admissions.

6. Was a psychiatrist's opinion concerning the patient's dangerousness to self or others given? (8)
   1=Yes 9=Unknown/No info
   2=No
   What was the rating? (9)
      1=Dangerous to self
      2=Dangerous to family or specific family member(s)
      3=Dangerous to others or specific other(s)
      4=Dangerous to self and others
      5=Dangerous to family and others
      6=Not dangerous to anyone
      9=Unknown/No info
   Certification alone should not be taken as an opinion re: dangerousness.

<u>Section F</u> <u>Forensic History</u>

1. Admission number (10)
   If it is not a first admission code type of readmission: (11)
   1=New offence
   2=Administrative (ie., a change of status on the basis of court disposition or provincial mental health statute. Also includes transfer from Riverview).

2. Admission date (12-17)
   Code as year, month, day.

3. Legal status of patient at time of admission (18)
   1=Remand-fitness assessment
   2=Remand-presentence
   3=WOC/Unfit
   4=WOC/NGRI (OIC/NGRI)
   5=Involuntary (s.20 MHA)
   6=Informal (s.19 MHA)
   7=T/A (Temporary Absence) (s.25 MHA)
   8=Remand-psych assessment
   0=Other
   "Remand-psych assessment" should be used when the

information requested does not include a fitness assessment or presentence recommendations but solely an assessment of mental state at time of offence and/or the existence of mental illness.

4. Diagnosis at time of admission (19-38)
   Enter diagnosis(es) listed in the first psychiatrist's report related to the current admission using DSM-III-R categories. In 19-33 enter three primary Axis I (Clinical Syndromes and V codes) diagnoses. In 34-38 enter primary Axis II (Developmental Disorders and Personality Disorders) diagnosis.

5. Characteristics of current condition (39)
   1=Exacerbation of chronic condition
   2=Recurrence of previous similar condition
   3=Indistinguishable from past
   4=Significant change from any previous condition
   9=Unknown/No info

6. Onset of current condition (40)
   1=Sudden
   2=Gradual
   3=Very gradual
   9=Unknown/No info

7. Precipitating stress (41-48)
   1=Drug reaction
   2=Financial problems
   3=Sexual problems
   4=School problems
   5=Occupational problems
   6=Family problems
   7=Traumatic incident
   8=Physical illness in family
   11=Physical illness in patient
   12=Someone's death
   13=Non-family interpersonal problems
   14=Withdrawal of prescribed drugs
   15=Multiple problems
   9=Unknown/No info
   0=Other change in life circumstances

   Enter the precipitating stress related to onset of current condition. If the 'multiple' category is used enter the three primary stresses in 43-48.

8. Number of patient days for each status during present admission as well as the total length of stay for the current admission. This information may be confirmed through the discharge registry. Enter length of stay in <u>days</u>. If duration is greater than 99 days, enter '00' and comment. If patient has not been discharged by June 1/88, enter length of stay up to that date only. The length of stay under the status of remand-psych assessment can be entered in columns 51-52 (remand presentence). N.B. Prior to ID#83 (88-07-20) length of stay was recorded in months, '00' was entered to indicated a stay of longer than 99 months and the actual length of stay was recorded in comments.

Remand-fitness assessment (49-50)
Remand-presentence/ psych assess (51-52)
WOC/Unfit (53-54)
WOC/NGRI (OIC/NGRI) (55-56)
Involuntary (57-58)
Informal (59-60)
T/A (Temporary Absence) (61-62)
Outpatient (63-64)
Total (65-67)

9. Discharge date (68-73)
Code as year, month, day.

10. Status at time of discharge (74-75)

1=WOC/Unfit
2=WOC/NGRI
3=Remand-Fit
4=Remand-Unfit
5=Remand-Presentence
6=Involuntary
7=Informal (voluntary)
8=Immigration-hold
11=Transfer back to correctional centre
12=Care of self
13=MOIC/NGRI
14=Deceased
15=OIC rescindment
16=Returned fit
17=Fitness not determined
18=Remand-psych assess
9=Unknown
0=Other

Enter the code for "Returned fit" only if the patient's admission status was WOC/Unfit.

11. Status Change (76)
When there has been a change in the patient's status during a single admission, enter what the status was (first) changed to using the same categories as in item 10. Subsequent changes should be recorded in comments (as well as indicated in 'length of stay' entries).

12. Date of Change (77-82)
Enter the date the first change in status took place. The date(s) of subsequent changes should be recorded in comments.

13. Identifier Code (1-3)

14. Admission Number (4)

15. Record Number 3 (5)

16. Diagnosis at time of discharge (6-25)
This may be found in the nurse's separation summary or on the medical file face sheet. Enter DSM-III-R Axis I (Clinical Syndromes and V codes) diagnoses (6-20) and Axis II (Developmental Disorders and Personality Disorders) diagnosis (21-25).

17. Treatment Recommendations (26-29)

1=Medication
2=Abstain alcohol/drugs
3=Individual therapy/ supervision
4=Group therapy
5=Community outpat.care (other MH facility)
6=FPC - outpatient care
7=Return FPI - treatment
8=Multiple
9=Unknown/No info
0=Other

These may be found in the letter to the court if the patient was returned to court as a remand. Not applicable to patients whose status changes from remand to informal. If the 'multiple' category is used, enter the primary three recommendations in 27-29. If there are no specific recommendations, leave blank.

18. Dispositional Recommendations (30-34)

1=FPC - outpatient care
2=Community outpatient care
3=Psychiatric hospitalization
4=Further inpatient assessment (return to FPI)
5=Custodial setting (correctional)
6=Bail
7=Probation/suspended sentence
8=Stay charges/involuntary
11=Stay charges/informal
12=Multiple
13=WOC/Unfit
14=WOC/NGRI
15=Reside in group home
9=Unknown/No info
0=Other

If the 'multiple' category is used, enter the three primary dispositional recommendations in 32-34. If the above categories are not specific enough enter exact recommendation(s) in the comments section. If there is no specific recommendation, leave blank.

19. Disposition (35-39)
    1=FPC - outpatient care
    2=Community outpatient care
    3=Psychiatric hospitalization/certification
    4=Further inpatient assessment (return to FPI)
    5=Custodial setting (correctional)
    6=Bail
    7=Probation/suspended sentence
    8=Stay charges/involuntary
    11=Charges stayed
    12=Charges withdrawn
    13=Charges dismissed
    14=OIC rescinded
    15=Multiple
    16=WOC/Unfit
    17=WOC/NGRI
    18=Not guilty-discharged
    9=Unknown/No info
    0=Other
    If the 'multiple' category is used, enter the three primary dispositions in 37-39. If the above categories are not specific enough, enter the exact disposition in the comments section. This information is readily available in the legal files of charts from 1980-1985 and may be checked against an available index (need discharge date).

Section G Criminal History

1. Previous criminal charges (regardless of outcome) (40)
   1=Yes
   2=No
   9=Unknown/No info
   If '1' is entered, code the type of offence giving priority to more serious offences (41):

1=Personal/violent	4=Public order
2=Property	9=Unknown/No info
3=Victimless	0=Other

   "Victimless" (eg. narcotics, soliciting).
   "Public order" (eg. drinking and driving offences, breach of probation, drunk in a public place, disturbing the peace).
   Enter whether the patient was remanded in custody on these charges (42)
   1=Yes
   2=No
   9=Unknown/No info

2. Previous criminal convictions (43)
   1=Yes
   2=No
   3=NGRI
   9=Unknown/No info
   If '1' is entered, code the type of offence (44):

1=Personal/violent	4=Public order
2=Property	9=Unknown/No info
3=Victimless	0=Other

   Enter whether the patient was sentenced to CJS incarceration (45)
   1=Yes
   2=No
   9=Unknown/No info

3. Charges related to present admission (46-65)
   Code first four charges as listed on court order using offence codes (46-48, 51-53, 56-58, 61-63). If the charge is a personal offence, code type of victim (49, 54, 59, 64):

1=Stranger	6=Parent
2=Police officer	7=Sibling
3=Friend/acquaintance	8=Other family member
4=Spouse	11=Other child
5=Own child	9=Unknown/No info
	0=Other

   If the charge is a personal offence, enter the number of victims (50, 55, 60, 65). Code up to seven victims as 1-7. Code more than seven victims as 8. Unknown/No info=9. Use the comments sections to provide details.

4. Weapons (66)
   1=None
   2=Hands and/or feet
   3='Domestic' (eg. frying pan, iron, scissors, clothing, electrical cord, umbrella, rope, tin cans, food, wire, wooden club/baseball bat, fireplace poker, tools, furniture).
   4=Knives (includes razor blades and axes).
   5=Firearms
   6=Poison
   7=Explosives/gasoline
   9=Unknown/No info
   0=Other
   This category refers to weapons used in the commission of the offence(s) related to the present admision. Use the comments section to provide details.

Section H Jail Assessment

1. Jail assessment prior to present admission. (67)
   1=Yes 9=Unknown
   2=No
   If a jail assessment was done prior to the present admission, who requested it? (68)
   1=Jail Physician 4=RCMP/Police
   2=Medical Officer 9=Unknown/No info
   3=Crown Counsel 0=Other

Section I Critical Incident

1. Number of significant events involving serious concern for the patient's own safety, or the safety of others occurring during the period covered by the present admission.
   Attempted or actual escape (69-70)
   Assault (71-72)
   code who was assaulted: (73)
   1=Staff 2=Patient(s) 3=Staff & patient(s) 0=Other
   Serious injury (74-75)
   Self injury (eg. suicide, slashing, pulling stitches, head pounding) (76-77)
   Property damage (eg. arson) (78-79)
   Assaulted (ie., patient assaulted by another patient) (80-81)
   Information related to critical incidents may be found in the nurse's notes. Provide details of self-injury in the comments section. Enter '00' if exact number of incidents is unknown and comment. An estimate of critical incidents is not available for those who are still in custody as of June 1/88 because nursing notes are not in files.

N.B.: Right justify all entries (i.e., fill the appropriate columns from right to left).
Use the comments section whenever the 'other' category is used and whenever more detail is deemed necessary.

APPENDIX II

OFFENCE/CHARGE CODES

STUDY CODE		CRIMINAL CODE
1. MURDER		
	1.1 MURDER	
111	first degree murder	214
112	second degree murder	214
113	infanticide	216
114	criminal negligence causing death	203
	1.2 MANSLAUGHTER	
121	voluntary manslaughter (in heat of passion, or with provocation)	215
122	involuntary manslaughter	217
	1.3 ATTEMPTED MURDER	
131	attempted murder	222
2. SEXUAL OFFENCES		
	2.1 SEXUAL ASSAULT	
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212	attempted rape	145
213	sexual assault with weapon/ threats/bodily harm	246.2
214	aggravated sexual assault	246.3

STUDY CODE		CRIMINAL CODE
	2.2 GROSS INDECENCY	
221	acts of gross indecency	157
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231	indecent assault (female)	149 (repealed 83/4/1)
232	bestiality/buggery	155
233	indecent assault (male)	156 (repealed 83/4/1)
	2.4 INCEST	
241	incest	150
242	step daughter/female employee	153
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252	feeble minded	148 (repealed 83/4/1)
253	with 16 to 18 year old	151
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312	assault causing bodily harm with intent/wounding	228
313	admin. noxious thing causing bodily harm	229

STUDY CODE		CRIMINAL CODE
314	overcoming resistance to commission of offence	230
315	tampering with transport (eg. bomb on a bus)	232
316	common assault causing bodily harm	245(2) (245.1 bodily harm/weapon; 83/4/1)
317	aggravated assault	245.2
318	abandoning child	200
319	assault of a police officer/ resisting arrest	246(2) (246(1); 83/4/1)
	3.2 KIDNAPPING AND ABDUCTION	
321	kidnapping	247(1)
322	unlawful confinement	247(2)
323	abduction of female	248 (repealed 83/4/1)
324	abduction of female under 16 (changed to abduction of person under 16;83/4/1)	249
325	abduction of person under 14	250
326	hijacking	76.1

STUDY CODE		CRIMINAL CODE
	3.3 COMMON ASSAULT	
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332	assault	244
333	common assault	245(1) (245; 83/4/1)
334	intimidation	381
335	libel	263
	3.4 DRIVING ASSAULTS	
341	criminal negligence in operation of vehicle/dangerous driving/failure to stop	233
342	impaired driving	234
343	driving over .08	236
344	failure to provide breath sample	234.1
345	driving while disqualified	238
4.1 ROBBERY		
411	robbery	302
412	attempted robbery	421
413	extortion	305
414	stopping mail with intent	304
5.1 OFFENSIVE WEAPONS		
511	possession of weapon or imitation	85
512	concealed weapon	87
513	pointing a firearm	84
514	possession of a prohibited weapon	88

STUDY CODE		CRIMINAL CODE
515	use of a firearm in the commission of an offence	83
516	use of explosive substance with intent	79

6. PROPERTY OFFENCES

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611	arson	389
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621	mischief/damage to property	387/388
622	setting fires	390
623	fire caused by negligence	392
624	false alarm fire	393
625	cruelty to animals	400,401, 402

7.1 PUBLIC ORDER/NUISANCE

711	harassing/indecent phone calls	330
712	threatening letters, phone calls	331
713	indecent acts	169
714	corrupting morals (printing/ mailing obscene matter)	159/164
715	disturbing the peace	171
716	obstructing/resisting/misleading a peace officer/obstructing justice	118/128/ 127
717	escaping lawful custody	133
718	trespassing	173

STUDY CODE		CRIMINAL CODE
719	failure to appear/breach of undertaking,recognizance, probation,parole,mandatory supervision	133/746/ 666/457
7.2 OTHER ACTS		
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724	violation of immigration laws	
725	breach of Juvenile Delinquency Act	
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811	breaking and entering	306
812	unlawful presence	307
813	possession of housebreaking tools	309
814	possession of stolen property	312
815	theft from the mail	314
816	fradulently obtaining food, lodging,transportation	322
817	forgery	324
818	uttering (forgery/ counterfeit money)	326/406
819	false pretences	320
820	fraud	338
821	theft	294/295
822	attempted theft	421
823	attempted breaking and entering	421

STUDY CODE		CRIMINAL CODE
9. DRUG OFFENCES		
911	possession,trafficking, importing etc.	Narcotic Control Act/ Food and Drugs Act