EXPLORING THE IMPACT OF *BILL C-30* ON THE HANDLING OF MENTALLY DISORDERED OFFENDERS

by

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Exploring the impact of Bill C-30 on the Handling of Mentally

Disordered Offenders

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Abstract

Bill C-30, proclaimed into law on Feb. 4, 1992, significantly changed a number of the Canadian *Criminal Code* provisions concerning mentally disordered accused persons. The old provisions had been criticized for some time for not providing sufficient procedural protections to these persons. Under the new legislation there is a presumption against detention, both for those undergoing psychiatric assessment, and for those found to be unfit to stand trial or Not Criminally Responsible on account of Mental Disorder (NCRMD). It is anticipated that mentally disordered accused persons will now spend less time in detention than was the case previously, and will be given greater "due process" protections in review hearings. It is also anticipated that more accused persons may now consider an NCRMD defence than before, since the consequences of being found NCRMD are (apparently) less onerous.

This dissertation examined the impact of the new law during the first year of its implementation in British Columbia, by using data from the files and patient information system of the B.C. Forensic Psychiatric Services, and information from interviews conducted with mental health and criminal justice personnel.

The main findings were as follows. In the first year of the new law: (i) the length of in-custody pre-verdict psychiatric assessments was shortened considerably; (ii) the clear majority of assessments were still held in-custody, despite a presumption in the new law that assessments be held out-of-custody; (iii) the review hearing, according to interview information, had become considerably more legalistic and adversarial in character; (iv) practices concerning discharge were apparently changing in that one quarter of new NCRMD

cases were given immediate conditional discharges, and there was a substantial increase in absolute discharges of pre-*Bill C-30* insanity acquittees; (v) an increase in the number of assessments of criminal responsibility was detected, although the interpretation of this result is problematic; (vi) there was a *perception*, held by clinical and prosecutorial staff, that there would now be more incentive to claim an NCRMD defence in the absence of any serious mental disorder; this view was contradicted by defence lawyers, and was not supported by clinical file data.

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Contents

List of Tables

List of Figures

Introduction: The Swain Decision, Bill C-30, and the Rationale for the Present Study

The Criminal Code and Mental Disorder

The apparently increasing presence of mentally disordered persons in the criminal court system has become a source of great concern for both mental health and criminal justice personnel (Freeman & Roesch, 1989; Schellenberg, Wasylenki, Webster & Goering, 1992; Teplin, 1991). One issue, which is the subject of this study, is whether such individuals are treated fairly in this system. In particular, this study is concerned with the new legislative provisions for handling mentally disordered persons laid out in the Canadian Criminal Code, which came into effect on February 4, 1992.

The Code contains a number of provisions that deal with accused persons who are apparently suffering from a mental disorder. This study focuses on two categories of mentally disordered accused persons: individuals who, because of mental disorder, may be unfit to stand trial; and, those who may be held not responsible for their actions at the time of their offence.[1]

The old Criminal Code provisions had been criticized for not providing sufficient procedural safeguards and for not adequately protecting the civil rights of mentally disordered accused persons (Law Reform Commission, 1975, 1976, 1986). In particular, there was

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1. It should be noted that these are two conceptually and temporally different issues. Fitness to stand trial concerns the mental state of an accused person at the time the accused appears in court, while criminal responsibility is concerned with the mental state at the time of the offence.

concern about the ultimate disposition of persons found either unfit to stand trial or not guilty by reason of insanity[2] (NGRI). In Canada such persons were subject to an automatic, indeterminate detention in strict custody until "the pleasure of the Lieutenant Governor was known." This harsh reality was quite at odds with the public perception that a successful insanity defence was a "ticket to freedom" (Ogloff, Schweighofer, Turnbull & Whittemore, 1992). Indeed, as Coles & Grant (1990, p. 244) suggest, "far from being a loophole, (the insanity defence) can become a noose that holds the accused person more tightly than any determinate sentence that might have been imposed." Further, one can see that holding persons found to be unfit to stand trial in secure custody for an indeterminate period is particularly unjust in that these persons have not been found guilty, or even tried, for their alleged offence.

In a 1976 report the Law Reform Commission of Canada suggested that the Lieutenant Governor's Warrant system:

> offended at least four basic tenets for decision-making in the criminal justice area, namely, that the disposition should be made openly, be made according to known criteria, be reviewable and be made of determinate length (Tollefson & Starkman, 1993, p. 2).

In this report the Law Reform Commission made a number of recommendations which, if implemented, would have resulted in a fundamental overhaul of the Criminal Code provisions relating to mentally disordered accused persons. In response to this report the Federal Department of Justice, in 1982, set up the Mental Disorder Project, headed by Gilbert Sharpe. The mandate of the Project was to prepare a set of recommendations that could be

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2. Referred to in the new Code as "not criminally responsible on account of mental disorder" (NCRMD).

used as the basis for changing the existing legislation. In carrying out this project a number of mental health and criminal justice officials were consulted. As well, the Project examined approaches used in other jurisdictions, including the United States and Great Britain. Notably, in a 1983 Discussion Paper, the Project emphasized the potential impact of the Canadian Charter of Rights and Freedoms on the law concerning mentally disordered accused persons.

The Project prepared a Final Report in 1985. On the basis of the recommendations contained in the Report, the then Federal Minister of Justice, John Crosbie, tabled a Draft Bill for consultation in the House of Commons on June 25, 1986. Most of the provisions contained in the Bill were well received; one exception was the provision for "capping" the length of time a mentally disordered accused could be held in disposition: Attorneys General from a number of provinces expressed concern that this would lead to the mandatory release of persons still considered to be a danger to the public. As well, concern was expressed by the provinces that implementing the new provisions would be excessively expensive (Tollefson & Starkman, 1993, p. 6). Proclamation of the new legislation was delayed while consultation with groups in the public and private sectors continued. It was hoped that the Bill could be considered for parliamentary approval in 1988; however, in this election year the then Minister of Justice, Ray Hnatshyn, was defeated, and plans to introduce the amendments were delayed while successive Ministers of Justice were briefed.

Ultimately, it was a Supreme Court of Canada ruling, Regina v. Swain (1991), that necessitated the immediate passage of new legislation. The Swain decision involved an Ontario man charged with assaulting his wife and children while apparently under the influence of a mental illness. The victims were not seriously hurt. After his arrest, the

accused was certified and transferred to a mental health facility, where his condition improved rapidly. Upon returning to jail he was granted bail. Swain's trial did not take place for another year and a half, during which time he lived in the community without further incident, and received psychiatric treatment on an outpatient basis. At trial, the Crown successfully raised an insanity defence, against the wishes of the accused, and notwithstanding the fact that his psychosis was by that time in remission. Swain was found not guilty by reason of insanity and, as prescribed by the legislation, ordered into strict custody to be held "until the pleasure of the lieutenant governor was known". He was given an absolute discharge about three months later.

In Regina v. Swain (1991), the Supreme Court dealt with two aspects of the insanity defence (Verdun-Jones, 1991a). The first concerned the common law rule that permitted the prosecution to initiate the defence against the wishes of the accused; the court recommended putting some restrictions on this prosecutorial discretion (this matter is discussed in more detail in Chapter Three).

The second aspect concerned the automatic, indeterminate detention of all persons initially found not guilty by reason of insanity (section 614(2) of the Criminal Code). The ruling of the majority was that this provision violated sections 7 (the right to life, liberty and security of the person) and 9 (the right not to be arbitrarily detained or imprisoned) of the Canadian Charter of Rights and Freedoms, that the provision could not be saved under s. 1 of the Charter,[3] and thus that it was invalid.

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3. The guarantees of the Charter are limited by s.1, which states that "The Canadian Charter of Rights and Freedoms guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic

While the decision focused on only one section of the Code, Chief Justice Lamer indicated that the other sections on which the lieutenant governor's warrant system was based "attracted suspicion" due to the lack of procedural safeguards (O'Mara, 1991).

Following its decision on May 2, 1991, the Supreme Court gave Parliament six months to enact new legislation more consistent with the Charter. This period was in fact extended for another three months; finally, on February 4, 1992, Bill C-30, entitled An Act to amend the Criminal Code (mental disorder) and to amend the National Defence Act and the Young Offenders Act in consequence thereof, was proclaimed into law.[4]

Bill C-30 changes substantially many of the Criminal Code provisions concerning mentally disordered accused persons. The Bill C-30 provisions are complex, and are reviewed in some detail in Chapter Three. At this point, however, it can be said that two objectives of the new legislation are to provide more procedural safeguards for the mentally disordered accused person, and to minimize restrictions on that person's freedom. Notably, there is a presumption against custody, both for persons whose mental state is being assessed, and for persons who have been found either unfit to stand trial or not criminally responsible on account of mental disorder (NCRMD). In sum, it may be that the emphasis on the protection of society that was inherent in the old law (Verdun-Jones, 1981) is now to be balanced by

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society." A test to determine whether a statute violates s. 1 was developed by the Supreme Court of Canada in Regina v. Oakes (1986).

4. The implementation of a few provisions has been delayed. These provisions concern the "capping" of dispositions, the "dangerous mentally disordered accused" category, and hospital orders (see Davis, 1993; McIntyre, 1992).

a greater consideration of the protection and rights of the accused.[5]

Rationale for the Present Study

This thesis is a study of the impact of Bill C-30, focusing on the first year of its implementation in British Columbia. In order to assess the potential importance of this study, it is necessary to address two related issues: i) the prevalence of the mentally ill in the criminal justice system, and ii) the need for policy evaluation.

i) Prevalence of the mentally ill in the criminal justice system. How the mentally ill are handled in the criminal justice system has become an important area for study because of the prevalence of these individuals in this system, and the challenges associated with managing them. In brief, there is evidence that the mentally ill are coming into contact with the Canadian criminal justice system in large numbers, and a perception that this flow will continue to increase because of deinstitutionalization in the mental health system, along with general population increases (Davis, 1992).

For some years the notion that the mentally ill were being "criminalized"[6] was based

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5. It is notable that legal reform in Canada has parallels with developments in Australia (Verdun-Jones, 1986) and England and Wales (Mackay, 1991); in these countries recent amendments to mental health statutes have provided, like the Canadian legislation, for more flexible dispositions for mentally disordered accused persons.

6. Defining "criminalization" is difficult, since, to the extent that it is happening, it is a complex, multifaceted process (Davis, 1992; Gingell, 1991; Roesch & Golding, 1985; Teplin, 1991). For the purposes of this study criminalization refers to the hypothesis that, as a consequence of deinstitutionalization in the mental health system, troublesome behaviour by mentally ill persons, that would have (presumably) been dealt with previously by the mental health system, is now being dealt with by the criminal justice system (Teplin, 1984). It has traditionally been assumed that the "troublesome behaviour" consisted mainly of minor offences. There is some evidence, however, that the mentally ill are being arrested, as well, for more serious infractions (Arvanites, 1988; Rabkin, 1979). There is also a counter-argument to the "criminalization" thesis: namely, that -- despite structural constraints --

on speculation and anecdotal information (Abramson, 1972). More recently, however, a number of well designed studies have suggested that the prevalence of serious mental illness (such as schizophrenia and bipolar mood disorder) in jail and prison populations[7] exceeds that found in the general population, both in Canada and the U.S. (Gingell, 1991; Hodgins, 1992). For instance Gingell (1991), in assessing 313 consecutive admissions to the Vancouver Pre-Trial Services Centre, found eight percent of the subject population to be schizophrenic, compared to lifetime prevalence rates of about one percent for the general population (American Psychiatric Association, 1987; Strayhorn, 1982). Similarly, Hodgins (1990) found in a survey of Quebec penitentiary inmates that the prevalence rate of schizophrenia among inmates was seven times higher than that of nonoffender males. Another study of the Vancouver Pre-Trial Centre by Hart & Hemphill (1989), which examined 576 admissions over a three-month period, determined that 24% of the inmates could be considered mentally disordered (according to the rating scales used) and 7% could be considered psychotic (currently experiencing delusions, hallucinations or thought disorder).[8] These authors found

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mental health and criminal justice personnel still have enough discretionary leeway to divert the mentally disordered offender into the mental health system in many instances (Arboleda-Florez & Holley, 1988; Lagos, Perlmutter & Saexinger, 1977; Levine, 1970) and, that there may be a general reluctance to prosecute the mentally ill (Corrado, Doherty & Glackman, 1989; Miller & Maier, 1987).

7. It should be noted that, in Canada, jails (or pre-trial centres) and prisons house somewhat different populations, with the former serving as lock-ups for persons awaiting a court appearance or sentencing, while the latter serve as places of detention for sentenced offenders. It is possible that rates of mental disorder may be higher in the jail setting than in prison, since, in some cases, mentally disordered persons will be diverted at the pre-trial stage into the civil and forensic psychiatric systems (Davis, 1992, in press), and after sentencing into regional psychiatric centres.

8. In a personal communication with one of these authors (Gingell), it was suggested that the high rates of mental disorder seen at the Vancouver Pre-Trial Services Centre may have to

that the "mentally disordered offenders, compared to non-mentally disordered offenders, were more likely to have security problems, required more resources to manage, and had a poorer attitude towards security staff" (p. 5).

It has been assumed that the "criminalization" of the mentally ill is due to deinstitutionalization in the mental health system, resulting in greater numbers of untreated mentally ill persons residing in the community. There are two aspects of deinstitutionalization which may be considered in evaluating this hypothesis. First, there is the fact that in Canada, over the last 40 years, there has been a considerable reduction in the number of provincial mental hospital beds; Herman & Smith (1989) note that the rate of hospitalization of the mentally ill in Canada has fallen from 4.25 per 1000 population in 1955 to 0.7 per 1000 in the early 1980s. In B.C., the number of beds at Riverview Hospital, the main provincial civil psychiatric facility, has fallen from about 5000 in the mid-1950s to about 1000 in 1993, with a 1987 B.C. Ministry of Health planning report suggesting that ultimately the hospital will have only 550 beds. In short, notwithstanding the fact that more psychiatric beds have been created in general hospitals, it seems fair to say that a greater proportion of the mentally ill are currently residing "in the community."

A second aspect of deinstitutionalization concerns changes in mental health legislation, with respect to the admission criteria and release procedures for psychiatric hospitalization. The contention has been that, with the narrowing of civil commitment criteria in many jurisdictions, it has become more difficult to gain involuntary admission for mentally ill

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do with the fact that the Centre serves an area with a large population of mentally ill persons -- including the downtown east side of Vancouver, where a number of mentally ill persons reside in single-room-occupancy hotels.

persons, so that the police, having to "do something" when faced with a mentally disordered person, may end up arresting the person "by default" (Teplin, 1984). Empirical support for this argument comes from Teplin's (1984) observational study of police activities in Chicago, where she found that police officers were frustrated by various bureaucratic and legal obstacles when trying to arrange hospitalization, or an informal disposition, for mentally disordered suspects. While Teplin's study has not been replicated in Canada, some comment can nonetheless be made on changes to mental health legislation in the Canadian context.

In Canada, from about the 1940s to the 1960s, most provincial mental health acts had rather broad involuntary admission standards, notably by including the "welfare test" (need for treatment) as a basis for civil commitment, which became "the focus of the (civil mental health) legislation" (Robertson, 1987, p. 329). By the 1970s, however, some jurisdictions (starting with Alberta in 1972) were turning to the concept of dangerousness in their commitment criteria. Ultimately, in B.C., (although not until 1987), the "welfare test" (the old s. 20(2) of the Mental Health Act) was repealed, so that now a committed patient must require "care, supervision and control in a Provincial mental health facility for his own protection or for the protection of others" (s. 20(3)). As well, the initial period of detention, following commitment, has been reduced in the B.C. Mental Health Act (s. 21(1)) from one year to one month (Clements, 1991).[9] Arguably, then, statutory changes have had the effect

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9. Although, as Clements (1991) points out, the Act does not provide any criteria to be applied at the time of renewal of detention; Clements suggests that "given the effect of the Charter of Rights and Freedoms, it seems reasonable to assume that the initial admission criteria still apply" (p. 161). In fact, in the recent B.C. Supreme Court decision in McCorkell (1993) (see discussion in footnote 9, infra) Justice Donald stated that "a review necessarily implies the application of the same standards used in the decision of the first instance."

of narrowing involuntary admission standards[10] and shortening periods of detention.

In sum, the "criminalization" hypothesis is supported, indirectly, by studies that have looked at the rate of mental disorder in jail and prison populations, and by the fact that there have been legal and structural changes affecting psychiatric hospitalization practices. Having said that, it should be noted that it has been exceedingly difficult to elucidate a cause and effect relationship between deinstitutionalization and "criminalization", that is, to demonstrate that prevalence rates of mentally disordered persons in the criminal justice system have been increasing over time, as a direct result of deinstitutionalization (Jemelka, Trupin & Chiles, 1989; Roesch & Golding, 1985; Teplin, 1983, 1991). This may have to do with methodological limitations and data availability.[11] It is possible, for instance, that the number

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10. Although, it is conceded, criteria referring to "dangerousness", or similar concepts, may still be interpreted in a rather broad fashion, (notably in several Ontario court decisions: see Robertson [1987]). The B.C. Mental Health Act, as noted, states that involuntary hospitalization is permissible when the "protection of self/others" is at stake. This standard was challenged in the (1993) B.C. Supreme Court case McCorkell v. Director of Riverview Hospital Review Panel and Attorney General of B.C., where the plaintiff argued, unsuccessfully, that the standard was "vague and overbroad", and thus denied him his liberty (under s. 7 of the Charter of Rights and Freedoms) and subjected him to arbitrary detention (contrary to s. 9 of the Charter). In dismissing this action, Justice Donald noted that "given the purpose of the Act -- the treatment of the mentally disordered who need protection and care -- the language must permit the exercise of some discretion"; he further indicated that "protection" could be seen as referring to protection from "social, family, vocational or financial" harm, beyond simply physical danger; in concluding, the opinion of the court was that the committal standards "strike a reasonable balance between the rights of the individual to be free from restraint by the state and society's obligation to help and protect the mentally ill", and thus were "not invalid on the doctrine of vagueness." Regardless of court decisions, individual physicians may interpret commitment standards in an idiosyncratic fashion (Bagby, Thompson, Dickens & Nohara, 1991).

11. An apparent link between deinstitutionalization and criminalization has been uncovered in a few studies: Penrose (1939), in an early study, found an inverse correlation between prison and mental hospital populations in several European countries; more recently, Arvanites (1988) found a correlation between the rate of deinstitutionalization in three U.S.

of mentally disordered persons in jail populations has always been high, but that they were under-identified previously (Steadman & Ribner, 1980). Nonetheless, even if there is no change in the prevalence rates of mentally disordered persons in the criminal justice system over time, it is clear that their absolute numbers will continue to grow, as a function of general population increases and increases in the prison inmate population.[12] Thus, it would appear that the mentally disordered offender will continue to present a challenge to criminal justice system officials for the foreseeable future.

With respect to the nature of the challenge the mentally disordered offender presents, it is fair to say that judges and prosecutors may feel ill-prepared to handle such a person, and at a loss when trying to come up with a suitable disposition (Kropp, Cox, Roesch & Eaves, 1989; Ogloff, 1991; Rogers & Bagby, 1992). The dilemma presented by the mentally disordered offender is neatly encapsulated in the following quote from a B.C. prosecutor:

> (Prosecutors) face some difficult ethical issues; it is not as simple as just leading the evidence which will tend to establish the guilt of the (mentally disordered) accused. Decisions must often be made whether the accused should be prosecuted at all. Should the Crown oppose a defence of insanity if it is led? Should the Crown introduce evidence of insanity if defence counsel does not? Prosecuting the mentally ill is a challenge not only because it calls upon one's skills as counsel and one's knowledge of law and procedure, but more especially because it forces one to step back and think carefully about the very purpose of a criminal prosecution. Is it to protect the public? Is it to reform the offender? And how are those purposes best achieved when the offender is mentally ill? (Committee on the Effects of Multi-Problem Persons, 1991, p. 51).

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states and increases in the frequency of incompetency commitments.

12. The Canadian penitentiary population has increased in absolute numbers from about 5000 in 1950 to about 13,000 in 1990; during this same period the rate of penitentiary incarceration increased from 51 persons per 100,000 population to 68 per 100,000 (Evans & Himelfarb, 1992).

The prosecutor is handicapped by a number of systemic problems, which will be explored in the present study. Prominent among these are a perceived lack of access to the civil mental health system, and the inflexibility, prior to Bill C-30, of dispositions in the forensic psychiatric system.

ii) The need for policy evaluation. The recent passage of Bill C-30 presented, fortuitously, an opportunity to evaluate, during the implementation stage, the practical effects of a piece of legislation that addresses the plight of mentally disordered persons in the court system. Campbell (1969) suggests that, while informed public policy-making dictates the need for evaluations of social reforms, in practice few such evaluations are ever carried out. In the arena of mental health law, Steadman (1987) echoes this sentiment, noting that a number of significant U.S. legislative changes lack empirical investigation. This author states that "the area in greatest need of a concerted research initiative concerns the effect of major judicial decisions and significant statutory changes on mental health law and the criminal offender" (p. 329). It was suggested to the author[13] that the situation in Canada is similar: the question of whether legal reforms actually achieve their aims, and the secondary consequences that may ensue, often go unaddressed. Indeed, in the present study, as will be detailed later, the author was given the impression that practitioners were scrambling to react to effects of the new legislation that were, to some extent, predictable, and that could have been dealt with, perhaps, more "proactively."

There are various reasons why social reforms may not be evaluated, such as funding issues and methodological problems. An additional reason, which deserves some comment,

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13. Personal communication with Professor Gerry Ferguson.

is the assumption that new reforms will simply work out "as intended." Using the example of Bill C-30, it can be shown that this assumption may be questionable.

To begin with, the "intent" of Bill C-30 is not always clear and, in fact, the provisions, which concern a wide range of procedural issues, are quite complex. Further, while it is apparent that there is now a greater emphasis on the rights and freedoms of the accused than was the case previously, the Code still provides room for discretion in the application of a number of the provisions. For instance, there is now a presumption that fitness assessments shall be undertaken out of custody, and in five days or less (previously these were done in-custody, for up to 30 days); on the other hand, such assessments may be extended to 60 days, in "compelling circumstances", and may be held in custody, where "the court is satisfied that custody is necessary." Thus, how this will be interpreted, and how discretion will be used, remains to be seen. Another example is the new provision for "protected statements", the purpose of which is apparently to prevent statements made by accused persons in pre-trial assessment from being used against them in court. The fact that the Code lists a number of exceptions to this rule -- instances where statements may be admissible -- would seem to make the use of this provision problematic.

Another reason why reforms may not work out "as intended" is that implementation may be limited by the inadequate provision of necessary resources (Cotterell, 1984, p. 61). For instance, the presumption that fitness assessments shall be done out of custody may be compromised by the fact that outpatient psychiatric facilities (particularly in outlying areas) may be lacking (see also Webster, Menzies & Jackson, 1982, p. 19).

There are other factors that may work against the intended implementation of a new

law (or policy). Organizations may be resistant to change; as McShane (1992) notes, this may have to do with a fear of the unknown, a reluctance to break up established routines, and "structural inertia." Further, there is some suggestion that psychiatrists, in particular, have considerable discretionary authority in the interpretation and utilization of mental health laws and policies, and thus are able, to some extent, to resist legal reform (Bagby, Thompson, Dickens & Nohara, 1991; Menzies, 1989; Paredes, Kanachowski, Ledwidge, Stoutenburg & Beyerstein, 1990).

Another consideration is the political climate: while we may presume that persons found "not criminally responsible" will now be released earlier than was the case before Bill C-30 (see Chapter Three), it is also possible that anticipated media portrayals and public backlash may have some influence on Review Board decisions. The media have (perhaps predictably) taken a somewhat sensational slant in their coverage of the new law. One example is a headline declaring that the Swain decision has "open(ed) the door for serial killers" (Pron & Duncanson, 1992).[14]

While the discussion so far has concerned "intended" consequences, with any law reform there may be unintended -- or what one might better call "secondary" -- consequences, that affect other parts of the system, or other, interconnected systems (Roesch & Golding, 1985). This may be particularly true with legislation affecting the mentally

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14. It might be noted that, while this study was being written (in the spring of 1993), a particularly controversial case involving a man found NGRI in 1983 -- for killing six members of his family -- was receiving a considerable amount of press coverage in the Lower Mainland. The accused person in this case was being considered for absolute discharge from (what was originally) a Lieutenant Governor's Warrant: see Hall (1993).

disordered offender, who is shunted between the criminal justice, civil mental health and forensic psychiatric systems. One of the major anticipated secondary consequences of Bill C-30 concerns the perception that the changes in the Criminal Code will attract more people to the forensic psychiatric system, in part because the defence of "not criminally responsible" (NCRMD) is now -- apparently -- a more attractive option than was the case previously (Ogloff, 1991; O'Mara, 1991; Grunberg, 1993). For example, in the 1991-92 Annual Report of the B.C. Forensic Psychiatric Services Commission, it is stated that:

> It is easy to predict that adaptations to the new processes and systems resulting from (the Bill C-30) Criminal Code amendments will be the major preoccupation for Adult Forensic Psychiatric Services for the foreseeable future (p. 7).

and, further:

> We had known for some years what the likely direction of the legislation would be, and this has given us ample time to predict the consequences. It remains to be seen whether our predictions -- greater number of remands, greater number of persons pleading insanity -- will turn out to be true (p. 3).

The issue of secondary consequences, that is, more persons attracted to the forensic psychiatric system, was also addressed in the present study.

In summary, for a number of reasons, the consequences of a law reform may not be, a priori, obvious or self-evident, but rather may be a legitimate and important topic for empirical investigation. Further, it is submitted that by looking at administrative issues and practices -- how personnel involved in the forensic psychiatric system actually operate -- we are looking at how policy is effectively shaped, notwithstanding formal rules and legislation (Cotterell, 1984; Friedson, 1986; McShane, 1992; Wilson, 1981).

Organization of the Dissertation

To provide some necessary background information, and to place the present study in context, Chapter Two provides a brief description of the Forensic Services and forensic assessment process in British Columbia -- the setting of the study.

Chapter Three provides a critical overview of the changes in the Criminal Code resulting from Bill C-30. Included is a review of the legal and social science literature that dealt with problematic aspects of the old Code provisions. An attempt is made to examine how -- or if -- Bill C-30 addresses the perceived deficiencies in the old law. The chapter concludes with a number of implications of the new law, which in turn form the basis for the empirical analysis that follows.

Chapter Four provides a description of the methodology of the empirical part of the study.

Chapter Five is a presentation of the results. This chapter is divided into ten sections, each of which corresponds to a particular issue concerning the effect of Bill C-30. All ten issues were examined by the use of interviews, and seven of the ten were examined by the use of archival data.

Finally, Chapter Six provides a summary of the main findings, a more general discussion of the results, and an attempt to place the results in a broader theoretical context.

Chapter Two

Forensic Psychiatric Assessments in British Columbia

This study is (in part) concerned with how forensic psychiatric assessments are conducted in B.C., and how these assessments may be affected by changes in the law under Bill C-30. Therefore, as a background to a more detailed discussion of the Bill C-30 changes, it is necessary to provide a brief description of the organization of forensic psychiatric services in B.C., and the nature of the assessment process. In describing the assessment process, the assessment of fitness to stand trial and criminal responsibility will be discussed separately.

B.C. Forensic Psychiatric Services

When the courts determine that an accused person, because of mental disorder, requires assessment, treatment, or (if found to be unfit or not criminally responsible) containment, this is the mandate of the B.C. Forensic Psychiatric Services Commission, which operates under the Forensic Psychiatry Act of British Columbia.[1]

The Commission operates a number of facilities for adult and juvenile patients. This study only concerns the adult clientele.

The Commission's main inpatient facility in B.C. is the Forensic Psychiatric Institute (F.P.I.) which (at the time of writing) is a 151 bed secure hospital located in Port Coquitlam, close to Vancouver. Inpatient psychiatric assessments are conducted at this facility; as well,

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1. The Forensic Services Commission operates as well under the mandate of other statutes; these include the Canadian Criminal Code (which of course figures prominently in the present study) and the Mental Health Act of British Columbia (which concerns the civil commitment and treatment of mentally disordered persons).

persons who, under the law prior to Bill C-30, were found to be unfit to stand trial or not guilty by reason of insanity (NGRI), were initially detained there. Psychiatric assessments performed at F.P.I. may be ordered at the pre-trial or trial stage of the proceedings (referred to in this study as pre-verdict assessments), where there is often some concern about the accused person's fitness to stand trial, or at the pre-sentence stage of the proceedings, where treatment options and dispositional recommendations are considered.

Persons first entering F.P.I. are placed in "strict custody", that is, must remain on the ward at all times. Persons found to be NGRI or Not Criminally Responsible, and detained at F.P.I., will gradually progress to other levels of custody: first, they will be given hospital grounds privileges, next, day passes to the community, and ultimately conditional discharge (outpatient) status, followed by an absolute discharge (where the original warrant is rescinded). It should be noted, however, that this gradual release process has changed as a result of the Bill C-30 provisions, which will be detailed in the next chapter.

The staffing at F.P.I. is multi-disciplinary. An attending psychiatrist is assigned to each patient; patients will also receive care on the wards from nursing staff. Patients may be referred as well to clinical psychologists and social workers. In review hearings, where the dispositions of persons found unfit or NGRI/NCRMD are reviewed, the hospital is represented by a "nurse case coordinator", who presents information to the Review Board.

At the time of writing, plans to replace F.P.I. with a new, larger facility were being developed. In the 1991-92 Forensic Psychiatric Services Annual Report it is acknowledged that the present facility is "aging and inadequate" (p. 7).

The Forensic Psychiatric Services Commission also operates several outpatient clinics.

The two established clinics are in Vancouver and Victoria. Newer clinics are, at the time of writing, starting up in Kamloops, Prince George and Nanaimo. The clinics would see persons found not guilty by reason of insanity (now: not criminally responsible) who had been conditionally discharged from F.P.I. The clinics also see mentally disordered persons on bail or probation, persons requiring pre-sentence reports, and sex offenders.

Fitness Assessments

Pre-verdict psychiatric assessments often concern the issue of the accused person's fitness to stand trial (Kunjukrishnan & Bradford, 1985; Webster, Menzies & Jackson, 1982).[2] The fitness issue may come up at trial itself, but more commonly arises at the time of the accused's first appearance in court. This matter may be initiated, shortly after arrest, by the police officer stating in his or her report that the accused appears to be mentally disordered. The accused may then be seen, in the lock-up, by a doctor, prior to the bail hearing. If the doctor feels the person is mentally ill, the prosecutor may ask the judge for an adjournment so that the accused person can be seen by a psychiatrist. Psychiatrists with the B.C. Forensic Psychiatric Services will attend for this purpose at pre-trial detention centres, on an on-call basis.

Following the jail assessment, the psychiatrist may recommend that the person have a more formal psychiatric assessment, in which case the prosecutor may apply to the judge for an assessment order. Prior to Bill C-30 these formal assessments were always done in custody at the Forensic Psychiatric Institute, and were for a duration of up to 30 days. There

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2. The rationale for ordering an assessment is, however, worded in a rather ambiguous fashion in the pre-Bill C-30 Criminal Code. This point will be discussed in more detail in the following chapter.

are provisions in the Criminal Code (under both the old and the new law) for extending this period if more time is required to complete the assessment.

During the formal assessment at F.P.I., the accused person will be interviewed by a psychiatrist; he or she may also have a social history and family assessment done by a social worker, and may be referred to a clinical psychologist for psychological testing. Accused persons will also have routine notes made in their charts by the ward nurse; these progress notes are often used by the psychiatrist to help form a picture of the person's level of functioning. In some cases persons will be given antipsychotic medication. Where the accused do not consent to having medication, and where their behaviour is extremely psychotic and unmanageable, they may be certified and treated involuntarily (under sections 20 and 25.2 of the Mental Health Act).[3] Finally, the attending psychiatrist gathers the different sources of information together, and writes an assessment report to the referring court.

Following the formal assessment, several dispositions are possible for the accused person.

In many instances, the psychiatric opinion is that the person is fit to stand trial; in these cases the accused person is sent back to court.

In some cases the opinion is that the person is unfit to stand trial. In this instance, unless the Crown elects to stay the charges, the person returns to court for a fitness hearing. A fitness hearing may also be held where the accused is returned to court as fit, but the judge disagrees with the psychiatric opinion. A number of studies suggest, however, that the rate

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3. It should be noted that the B.C. Mental Health Act has been under review, with a view to amending some of the existing provisions; at the time this study was completed, however, the review process had ground to a halt.

of judicial agreement with psychiatric opinion on fitness is quite high (Menzies, 1989; Nicholson & Johnson, 1991). Ogloff (1992) found for the year 1989 that courts in B.C. agreed with Forensic Services' findings of unfitness (following F.P.I. assessment) 66% of the time (37 out of 56 cases). If the conclusion of the hearing was that the person is unfit, the usual practice in B.C., prior to Bill C-30, was to detain the individual in-custody, at F.P.I., until fitness was restored. Release decisions concerning persons found to be unfit (or not criminally responsible) are made by the Court or by a Board of Review; prior to Bill C-30, the review board's conclusions had to be approved by the provincial cabinet.

In some cases, persons sent out to F.P.I. for a pre-verdict assessment would have their charges stayed[4] by the prosecutor while at F.P.I., on the condition that they would be certified and consequently detained for treatment under the Mental Health Act. The determination of whether or not to stay charges is based (presumably) on the seriousness of the offence. There are several possible outcomes for patients who have been diverted into the mental health system in this fashion. The more seriously disturbed are waitlisted for, and may be transferred to, Riverview Hospital, which is the main (civil) adult provincial psychiatric institution in B.C.[5] Other patients at F.P.I. may be de-certified and discharged by the

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4. "Staying" a charge means suspending it, rather than dropping it. In theory this means the charge could be reactivated (no later than one year hence, for indictable offences, or six months hence, for summary offences); however, in practice, it is apparently unusual for the Crown to reactivate charges once they have been stayed. On the other hand, as Griffiths & Verdun-Jones (1994, p. 308) point out, "there is nothing to prevent the prosecutor from initiating fresh proceedings for the same offence, provided that (as far as summary conviction offences are concerned), this is done within the appropriate limitation period."

5. The policy in B.C. has been to continue to reduce the number of beds at Riverview, so one may presume that it will become increasingly difficult for forensic patients to gain access to these beds. The author was also given the impression, during interviews, that forensic

attending psychiatrist. Some civilly committed patients may apply to, and be released by, the review panel.[6] And, in a small number of cases, de-certified patients may stay on for a short time on a voluntary basis.

This practice of using psychiatric remands as a way of diverting people involuntarily into the mental health system has been criticized (Rogers & Bagby, 1992; Verdun-Jones, 1981). On the other hand, it can be argued that this is the most humane course to follow, particularly in view of the fact that treatment resources in correctional facilities and pre-trial centres are often inadequate (Butler & Turner, 1980; Hodgins & Cote, 1990, 1991; Kropp, Cox, Roesch & Eaves, 1989; Teplin, 1984). The Law Reform Commission (1976) in fact suggested that diversion of the mentally ill accused person may often be in the best interests of that person and society, adding that prosecutorial policy in this regard should be "visible" and "consistent." In sum, while fitness assessment may be the ostensible reason for ordering the remand, diversion or dispositional recommendation may be the "real" issues facing the court (Ogloff, 1991; Rogers & Bagby, 1992).

Assessment of Criminal Responsibility

In addition to fitness, criminal responsibility (i.e., mental disorder at the time of the offence that might negate the fault requirement) may be addressed in forensic psychiatric assessments. This may happen either at the pre-trial or pre-sentence stage. In his study of the

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patients were not popular with the Riverview staff.

6. The reader should be aware of the difference between the review panel, which deals with civilly committed persons (see section 21 of the B.C. Mental Health Act), and the review board, which deals with persons held as unfit or not criminally responsible on account of mental disorder.

Metropolitan Toronto Forensic Service, Menzies (1989) found that relatively few pre-trial assessments did in fact address criminal responsibility. On the other hand, Ogloff (1991) found that in B.C. this issue was requested relatively frequently for F.P.I. pre-trial admissions.[7] This inconsistency between jurisdictions may be partly due to the in-house referral forms used in B.C., which explicitly (prior to Bill C-30) offered "mental state at the time of the offence" as one of the assessment options for the referring person to check off; as well, there was apparently a policy in the Toronto Forensic Service of not addressing criminal responsibility at the pre-trial stage (Butler & Turner, 1980). The Law Reform Commission (1976) in fact suggested that the relevant issues to be addressed in pre-trial assessments were fitness and diversion (not criminal responsibility). The old Criminal Code provisions were vague about the purpose of psychiatric assessment of an accused person (a point that is dealt with in more detail in the next chapter); the new Code provisions, however, explicitly state that assessment may be ordered to determine criminal responsibility and that this may occur "at any stage of the proceedings" (s. 672.12).

Prior to the Swain (1991) decision, the Crown had the right to raise an insanity defence, even over the objections of the accused (Verdun-Jones, 1989a). In his survey Ogloff (1991) found that (prior to Swain) a number of B.C. defence counsel objected to the idea of the Crown unilaterally investigating the issue of criminal responsibility; one interview subject had the perception that this was a prosecutorial strategy to "put away" people by means of the indeterminate detention of people found NGRI. To be fair, it may also be that the Crown

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7. There may be some question about the interpretation of this finding, a matter that is dealt with later in this study.

has a legitimate concern for not convicting a person who did not have the necessary fault to be found guilty of a crime. The Crown may also feel, in anticipation of an insanity defence, that the best evidence concerning a person's mental state at the time of the offence comes from an assessment close to the time of that offence, i.e. shortly after arrest. It may be noted that, while the ruling in Swain put some limits on the prosecutions's ability to raise the defence of (what is now called) Not Criminally Responsible, Bill C-30 still provides considerable scope for the prosecution in assessing criminal responsibility (short of bringing up the full-fledged defence).

Chapter Three

Bill C-30: Changes in the Criminal Code and their Implications

This chapter provides an overview of the changes in the Criminal Code brought about by Bill C-30. The discussion here concerns persons who are suspected of being unfit to stand trial, or not criminally responsible on account of mental disorder.

The discussion follows the sequence of events as they would arise for an accused person entering the forensic psychiatric system, and thus is organized under the following subheadings:

1) Raising the issue of fitness: who may raise this issue, at what stage in the court proceedings, and what are the procedural safeguards?

2) Raising the issue of mental state at the time of the offence: as above, who may raise this issue, at what stage in the proceedings, and what are the procedural safeguards?

3) Assessment orders: in assessing the mental state of an accused person, how clear is the purpose of the assessment, what is the duration and location of assessment, and what protections exist against self-incrimination during assessment?

4) Substantive aspects of fitness to stand trial.

5) Substantive aspects of the defence of not criminally responsible on account of mental disorder.

6) Dispositions of persons found to be unfit to stand trial or not criminally responsible on account of mental disorder: in particular, what is the role of the review board, what are the procedures of the review board hearings, what criteria are used

to determine discharge, what are the terms of the dispositions, and what provisions exist for appeals?

To help contextualize the Criminal Code changes the overview will include some of the criticisms of the old provisions from the legal and social science literature.

At the end of the chapter, as a lead-in to the empirical part of the study, the main implications of the Criminal Code changes will be reviewed.

Finally, it should be noted that references to the "old" and "new" Criminal Code provisions in this chapter indicate the law immediately before and after the implementation of Bill C-30 (Feb. 4, 1992).

Raising the Issue of Fitness

One of the criticisms of the old Criminal Code provisions concerned the discretion given to the prosecution in raising the issue of fitness to stand trial, possibly against the wishes of the defence, and possibly in the absence of a strong case against the accused (Verdun-Jones, 1981). This criticism stemmed from the fact that an assessment of fitness to stand trial could result in a significant deprivation of liberty for the accused: typically a 30 day in-custody remand for the assessment itself, then, if the accused was subsequently found unfit, an indefinite period of detention in a psychiatric facility. The criticism also had to do with the perception that fitness assessments were being used for "extralegal" purposes by the prosecution, that is, to gather information about the accused that could be used later at court, or to dispose of the case by arranging for the civil commitment of the individual (Rogers & Mitchell, 1991, pp. 106-109).

Under the old Criminal Code provisions the question of fitness could be postponed until the end of the case for the prosecution (s. 615(5)(a)); further, it was stated that if the accused were acquitted at the close of the prosecution's case the issue of fitness would not be tried (s. 615[8]). Critics argued that these provisions for postponing the issue did not go far enough. The Law Reform Commission (1976) argued that the fitness issue should not be heard until after the full trial on the merits -- provided the defence had a viable case -- so that the accused could present a defence. If found innocent, the fitness issue would not be tried; if guilty, a fitness hearing would follow the conditional verdict. Lindsay (1977) argued that the accused should have "an unqualified right to present his defence" (p. 345). Roesch (1977) suggested that by going ahead with the trial unnecessary fitness remands would be avoided, and further, that the trial in fact represented the best "in situ" method for determining fitness.

Notwithstanding these recommendations, and the provisions in the old Code, it seems that the practice has been to not postpone addressing the question of fitness (Lang, 1990; Mohr, 1978). Notably, a 1982 survey of B.C. judges, prosecutors and defence counsel found little support for the idea (Eaves, Roesch, Glackman & Vallance, 1982). Del Buono (1975) raised the objection that postponing the issue subverted the very intent of the fitness provision: to protect an accused from having to make a defence when unfit; Roesch (1977), on the other hand, noted that a majority of fitness remandees were found to be fit following the assessment, suggesting that, for some at least, the remand may have been unnecessary.

With Bill C-30 there is greater provision for postponing the issue of fitness. Section 672.25 (2)(b) of the Code states that the court may postpone the issue "on motion of the accused, (to) any later time that the court may direct"; that is, to the end of the trial. Whether the courts will elect to use this option is another matter.

The new Code provisions also address postponing the issue at the point of preliminary hearing, something not dealt with in the old Code. Section 672.25(2)(a) now states that the fitness issue may be postponed until the end of the case for the prosecution. The implication is that there may be a greater onus on the prosecution to make a prima facie case against the accused, something they apparently did not have to do before (Lindsay, 1977).

Finally, the new Code provisions limit the prosecution's ability to request a fitness assessment for summary offences: the court may order the assessment only if "the accused raised the issue of fitness" or if "the prosecutor satisfies the court that there are reasonable grounds to believe that the accused is unfit" (s. 672.12[2]). Of course, in practice, it may not be difficult to come up with "reasonable grounds".

Raising the Issue of Mental State at the Time of the Offence

The old Criminal Code did not address the issue of who could raise the insanity defence. The common law rule in Canada was that, in addition to the defence, the prosecution or the court could raise the issue, regardless of whether or not the accused wanted the issue to be raised (Verdun-Jones, 1991a).

There are several problems with this rule, and these were dealt with by the Supreme Court in the Regina v. Swain (1991) decision. The court noted that raising the

issue of insanity could imperil the liberty of the accused, since, if found Not Guilty by Reason of Insanity (NGRI) the accused would be automatically subject to an indeterminate detention in a psychiatric facility, regardless of the seriousness of the charge. As well, it was noted that the credibility of the accused could be undermined if he or she were perceived to be insane by the judge or jury. Further, the prosecution's ability to raise the defence over and above the wishes of the accused violated the fundamental right of that person to control his or her own defence. It was found that the old common law rule violated section 7 (the right to liberty and security of the person) and section 15 (equality rights of the disabled) of the Canadian Charter of Rights and Freedoms.

In the Swain (1991) decision the Chief Justice suggested a new common law rule: henceforth the prosecution could only raise the issue of insanity at the time of the offence if (a) the matter of the mental state of the accused had already been raised by the defence, or (b) the accused had otherwise been found guilty of the offence. Verdun-Jones (1991a) notes that the second situation still means that an accused, although found guilty of a crime, could be detained for longer as an insanity acquittee than he or she might have if sentenced and incarcerated, particulary if the charge was minor. This, however, is less likely to occur now that the dispositions for persons found NCRMD are less onerous, something that will be discussed in more detail later in the chapter.

The new Criminal Code provisions now explicitly address the question of who may order an assessment to determine whether the accused is not criminally

responsible on account of mental disorder (NCRMD). Section 672.12 notes that this request may be made by the court, of its own motion, or by the accused. It may also be made by the prosecutor, but only if (a) the accused puts his or her mental capacity for criminal intent into issue, or (b) the prosecutor satisfies the court that there are reasonable grounds to doubt that the accused is criminally responsible for the alleged offence. The latter provision may still offer the prosecutor considerable leeway with respect to ordering assessments of criminal responsibility. Information thus derived about the accused's mental state at the time of the offence will presumably still have to meet the requirements of the new common law rule, mentioned above, before it could be entered into a trial.

Assessment Orders

The old Criminal Code contained several provisions for the ordering of a psychiatric assessment of an accused person at the point of preliminary hearing or trial. The new Code similarly allows "a court having jurisdiction over an accused" to make (what are now called) "assessment orders" (s. 672.11). There have, however, been a number of changes that concern the nature, duration and location of the assessment, and these will be discussed in this section. The focus here will be on assessments at the pre-trial stage, not at the sentencing stage; pre-sentence assessments have been less affected by the Bill C-30 changes than have pre-trial assessments, and in fact address somewhat different issues.

i) Purpose of Assessment. Prior to Bill C-30, psychiatric assessments at pre-trial were often ordered when there was some question about the accused person's

fitness to stand trial. Menzies (1989, p. 181) argued that "at a pre-trial level, fitness is the only clinical judgement that is legally mandated by the (old) Canadian Criminal Code" (see also Addington & Holley, 1987). Similarly, the Law Reform Commission (1975) suggested that the relevant issues before trial were fitness, and the possibility of diversion from the criminal process.

In practice, however, the assessment could address a number of issues in addition to fitness, such as certifiability, mental state at the time of the offence (i.e. criminal responsibility), dangerousness, treatment and dispositional recommendations, and even some opinions on sentencing (Menzies, 1989; Ogloff, 1991; Webster, Menzies & Jackson, 1982).

An expansive sort of assessment may, indeed, be useful to Crown prosecutors, who, as Ogloff (1991) notes, are often frustrated in their dealings with mentally ill offenders and glad to have any help in coming up with dispositional alternatives.

There has been concern, however, about the legal and ethical basis for addressing such a wide range of issues (other than fitness) at the pre-trial stage (Butler & Turner, 1980; Melton, Petrila, Poythress & Slobogin, 1987; Ogloff, 1992). In particular, it has been argued that commenting on the potential dangerousness of an accused may prejudice their case when they return to court and are sentenced (Lang, 1990; Law Reform Commission, 1975; Menzies, 1989). Rogers & Bagby (1992, p. 410) suggest that even treatment recommendations, if related to the index offence (e.g. "he needs anger management"), can be prejudicial to the accused's case. As well, discussing the nature of the offence with the accused could lead to self-incrimination,

since psychiatrist-patient communications are not given a blanket privilege in Canada, and may (depending on the circumstances) be admitted at court (Ho, 1980);[1] in fact, in a survey of B.C. defence counsel Ogloff (1992) found that some held the perception that fitness remands were used as a "fishing expedition" to help the Crown. Further, with the prospect of an indefinite detention if found Not Guilty by Reason of Insanity, defence counsel might be concerned about the prosecution initiating an assessment of the accused's mental state at the time of the offence. (This last concern has, of course, been affected by the Swain ruling, where the prosecution's ability to raise this issue, and the consequences for the accused, have been altered.) And, while using the assessment to certify and divert the person to the mental health system might be a humane alternative,[2] there is the concern that the accused might consequently spend a longer period detained in a psychiatric facility than he or she would have in the criminal justice system if returned to court and sentenced.

Part of the problem was that the purpose of psychiatric assessments was not clearly stated in the (old) Criminal Code provisions. While fitness might be the primary issue in pre-trial assessments, the Code in fact made no reference to fitness, only to mental illness: for instance s. 537(1)(b) stated that an assessment could be

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1. The recent Supreme Court of Canada opinion in Gruenke (1991), concerning privileged communications, was that decisions about admissibility should be made on a case-by-case basis; this ruling is discussed in more detail later in this chapter.

2. The Law Reform Commission (1976) in fact suggested that (depending on the circumstances) pre-trial diversion of the mentally ill accused might often be in the best interests of the accused and the public. See also Butler & Turner (1980), where the authors suggest it may be unethical not to certify severely mentally disordered persons in this situation.

ordered at the point of the preliminary hearing "where....there is reason to believe that the accused may be mentally ill." It has been suggested that, in the absence of a specific mandate, psychiatrists may consequently expand their assessment to address a variety of issues (Lindsay, 1977). Indeed, clinicians themselves have expressed frustration about the vagueness of referrals from the courts (Addington & Holley, 1987; Owens, Rosner & Harmon, 1985).

One recommendation has been that the use of standardized referral forms, where the courts delineate their reasons for ordering an assessment, would help clarify the purpose of pre-trial psychiatric assessments (Webster, Menzies & Jackson, 1982). In fact such forms have been used for a number of years by the B.C. Forensic Psychiatric Commission; an example of the form used prior to Bill C-30 is given in Appendix A. What is notable from inspecting this particular form is that it allows a fair degree of expansiveness, i.e., the referring person may check off "existence of mental illness (including certifiability), fitness to stand trial, mental state at the time of offence, treatment needs, personality assessment, social assessment, and other recommendations (unspecified)".

The Law Reform Commission (1976) recommended that the Criminal Code itself be changed to more clearly state the purpose of psychiatric assessments. This recommendation is reflected in the new Code, where the purpose of psychiatric assessment has been made more explicit. Now, an assessment is made to determine: fitness to stand trial; whether the accused qualifies for a defence of not criminally responsible on account of mental disorder (NCRMD); or whether the accused qualifies

for a defence of infanticide (s. 672.11). In addition, there are provisions in this section for ordering an assessment to determine the disposition of persons found unfit or NCRMD, and for making a hospital order (although hospital orders, at the time of writing, are not in effect).

As well, the Code now provides a form (see Appendix B) that clearly lists the service(s) to be provided. The form used by the courts before did not, as per the old Code, indicate what service was to be provided.

Notably, the B.C. Forensic Services Commission has also produced a new referral form (see Appendix C), apparently to be consistent with the new Criminal Code; gone, then, are "certifiability, treatment needs, personality and social assessment, and other recommendations" as options on the new Forensic referral form. Unfortunately, to complicate matters, it was discovered in the course of the research for this thesis that the old Forensic referral form was still in use after Bill C-30; the significance of this will be addressed in the Results chapter.

Assessment to determine mental state at the time of offence is now explicitly recognized in the Code. As noted earlier, there was concern under the old law that this sort of assessment was unfair to the accused -- if it was initiated by the prosecution, against the wishes of the accused -- in that being found NGRI could mean an indefinite detention. Presumably it is now felt that there are sufficient safeguards in place, that limit the prosecution's ability to raise the issue, and that limit the potentially onerous dispositions.

An apparent implication of these changes is that the purpose of individual

psychiatric assessments is now narrower and more explicit. For instance, a pre-trial fitness assessment will mean (presumably) that only "fitness" is checked off on the referral form and, correspondingly, that only fitness will be addressed in the psychiatrist's letter to the court. Whether in practice the new forms will dictate the nature of psychiatric assessments, however, remains to be seen; for example, with respect to psychiatric form-writing, studies of the composition of civil commitment forms have found that psychiatrists do not always follow prescribed legal standards (Paredes, Kanachowski, Ledwidge, Stoutenburg & Beyerstein, 1990).

There is also now the potential for an increased volume of assessments, since the number of official reasons for assessment has increased (with assessments possibly being ordered now to determine disposition of unfits and NCRMDs).

ii) Duration of Assessment. In the old Criminal Code a remand for psychiatric assessment was for a period "not exceeding 30 days" (with provision for an extension to 60 days in exceptional circumstances). While the person could return to court in less than 30 days, Lindsay (1977) suggests that the practice in Canada has been to use the full assessment period. A study done in B.C. (Roesch, Eaves, Sollner, Normandin & Glackman, 1981) found that in the late 1970s persons were being held for an average of about 20 days for fitness assessments. Critics have argued that this is an inordinate length of time to be deprived of one's liberty, particularly if the remand is for a pre-trial fitness examination, where the person has not yet been convicted of any crime. This is especially so when one considers that most persons are found fit at the end of the assessment (see Ryan [1992] for B.C. data), so that, arguably, many of the

remands are unnecessary. The suggestion has been made that, in most cases, fitness can be adequately assessed in relatively brief, out-of-custody assessments (Law Reform Commission, 1976; Lindsay, 1977; Ogloff, 1991; Roesch, 1977; Roesch & Golding, 1979, 1980; Rogers & Mitchell, 1991).

In the new Code the period for assessments of fitness (only) has been reduced to five days, unless the accused consents to a longer period (s. 672.14[2]). It is possible that judges may be more disposed to order an in-custody fitness assessment if it is felt that the deprivation of liberty (five days) is minimized.

There is, however, a provision for extending the assessment period (up to a total of 60 days) "where the court is satisfied that compelling circumstances exist that warrant it" (s. 672.14[3]). Further, section 672.15 states that a court, of its own motion, or on the application of the accused or the prosecutor, may extend an assessment order for up to 30 days if more time is needed to complete the assessment. In short, notwithstanding the five-day provision, the option of extending the assessment period still exists if felt to be necessary.

One other potential ramification of the shorter remand period deserves some comment. It was noted above that since most people are found fit at the end of a 30-day remand, the remand is (arguably) unnecessarily long, i.e. they would have been found fit at the end of five days (or one day, for that matter). The counterargument is that, for some people at least, 30 days is needed to restore fitness by treatment (see Addington & Holley, 1987 and Lindsay, 1977), usually with antipsychotic medication. If this is true, then one could hypothesize that the number of people found unfit at the

end of assessment might increase. (The relationship between length of remand and rates of unfitness was examined in the present study: see "Issue Number Four" in Chapter Five.)

Further to the issue of treatment in assessment, the new Criminal Code states that treatment may not be ordered as part of an assessment order (s. 672.19). Presumably, then, if involuntary treatment is deemed necessary by clinical staff, the accused will be certified under the Mental Health Act, which was the normal practice prior to Bill C-30. However, the Code does now provide for involuntary treatment of persons found to be unfit after assessment (i.e. when under a disposition order); the potential complications of this provision are discussed in a later section in this chapter.

iii) Location of Assessment. The old Criminal Code provisions did not require that assessments be done in custody, but in practice this was usually the case. Thirty-day psychiatric remands in B.C. were always carried out at the Forensic Psychiatric Institute in Port Coquitlam. A number of arguments are commonly given to justify this: mentally ill persons are not good at keeping office appointments, inpatient status allows for better observation, treatment (if necessary) is easier to administer, and the "public is protected". One can make the argument that this is a somewhat unfair practice, in that "normal" persons might often be granted bail for similar offenses (Lang, 1990; Roesch, Eaves, Sollner, Normandin & Glackman, 1981).[3] Some have

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3. The counterargument here is that the fitness hearing is a non-adversarial process, where the principles of the bail hearing do not apply, and where the "best interests" of the accused -- which might mean in-custody assessment -- are paramount, and are the responsibility of

suggested that psychiatric remands are invoked deliberately, notably in police reports,[4] as a way of preventing the pre-trial release of persons considered to be dangerous (see Menzies, 1989, pp. 53-78).

In the new Code there is explicitly a presumption against custody for persons under an assessment order, except, firstly, where it is a serious offence, or, secondly, where "the court is satisfied that on the evidence custody is necessary to assess the accused" (s. 672.16). In short, this provision, as with the one concerning length of assessment, leaves a lot of room for discretion; consequently, it remains to be seen whether outpatient assessments will be commonplace. It is notable, however, that in a 1982 survey a substantial number of B.C. Crown prosecutors disagreed in principle with the idea of outpatient fitness assessments (Eaves, Roesch, Glackman & Vallance, 1982) and in a 1991 survey a majority of B.C. prosecutors disagreed with the idea of outpatient NGRI assessments (Ogloff, 1991).

iv) Protected Statements. As was touched on earlier in this chapter, there has been concern that information divulged by an accused person to a psychiatrist in a pre-trial assessment could be damaging or self-incriminating, since psychiatrist-patient communications are not privileged in Canada in the way lawyer-client communications

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all the officers of the court (see Weisstub, 1980, p. 543).

4. In the forms used by the police in B.C. there is a "tick box" on the first page where the arresting officer may request that a psychiatric examination be performed on the accused; as well, in "mental disorder" cases, the officer usually writes "hold for doctor" on this first page. In the present study it was found that, in some cases, the officer would write additional comments in the narrative portion of the report, such as: "this person is mentally disordered, a danger to the public, and should be held in-custody", indicating, presumably, that the individual was a poor candidate for bail.

are (Butler & Turner, 1980; Marshall, 1992; Schiffer, 1978; Verdun-Jones, 1981). The old Criminal Code provisions were silent on this matter. An example of this sort of problem occurred in the case of Re Waterford Hospital v. The Queen (1983), where the police used information gained in a fitness assessment to secure a search warrant, in order to search the premises of the accused person; the hospital sought to quash the warrant, and, ultimately, the issuance of the warrant was overturned by the Newfoundland Court of Appeal.

The Supreme Court of Canada made a ruling on the issue of privileged communications in the case of Gruenke v. The Queen (1991). In this case, the Crown was allowed to introduce incriminating statements that the accused (who was charged with murder) had made to a religious counsellor; after the accused was convicted an appeal was launched on the basis that the statements made to the counsellor should not have been admissible. In dismissing this appeal, the Supreme Court ruled that there should be no blanket privilege given to this type of communication, but rather that a decision about admissibility should be made on a case-by-case basis. Privilege would be recognized if the case met the so-called "Wigmore criteria"; a key criterion is that communications may be considered privileged if they originate in the confident belief that they will not be disclosed (in the case of Gruenke it was ruled that this criterion had not been met).[5] In commenting on the Gruenke case, Marshall (1992) suggests

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5. It should be noted that the fourth Wigmore criterion states that "the injury that would inure to the relationship by the disclosure of the communications must be greater than the benefit thereby gained for the correct disposal of litigation." It may be that the successful prosecution of a person charged with a serious crime would carry considerable weight in this sort of determination.

that, notwithstanding the court's decision, certain types of doctor-patient communications should, arguably, be given the same prima facie privilege given to the lawyer client relationship; notably, she suggests that the fitness assessment should fall into this category, since the "communications (gained in the fitness assessment) are inextricably linked with the very system which desires the disclosure of the communication" (p. 113).

With respect to forensic psychiatric assessments, clinicians may warn the patient that what they say will not be held in confidence (this is done routinely in the B.C. Forensic Psychiatric Services); hence, one would presume that the Wigmore criterion for non-admissibility is not met. There is, however, the danger that individuals (particularly if they are mentally disordered) will not understand this warning (Lindsay, 1977; Ogloff, Wallace & Otto, 1991);[6] even if they do understand the warning, accused persons in the context of the clinical examination -- where the psychiatrist is perceived as "helper" -- may still become expansive and make potentially incriminating statements (Butler & Turner, 1980). It may be that in some jurisdictions the Crown will make an informal agreement with forensic psychiatrists so that the latter will not have to provide "fact" information based on what was told to them by the accused; Butler & Turner (1980) suggest that such an agreement exists in the Toronto Forensic Service. On the other hand, it is noteworthy that Ogloff (1991), in his B.C. survey, found that a number of defence counsel were suspicious

6. This was also suggested to the author, in the present study, during an interview with a defence lawyer.

that psychiatric remands were in fact being used as "fishing expeditions" to gain information about the accused that might be useful at trial; some routinely advised clients "not to tell anybody anything" while at the Forensic Psychiatric Institute. (Crown Counsel who were interviewed disputed this interpretation of the process.)

Because of these problems, Lindsay (1977) makes the recommendation that "inculpatory statements made to the psychiatrist (should be) inadmissible at the trial of the main issue" (p. 337). This recommendation has apparently been followed in the new Criminal Code, where it is stated that communications from an accused during an assessment are "protected statements" and are not admissible in evidence (without consent) in any proceeding before a court or tribunal (s. 672.21). This new provision may offer limited protection, however, in that there are a number of exceptions to the rule limiting admissibility. Notably, a statement is admissible if it is "inconsistent in a material particular" with a statement made later at court (s. 672.21[3][e]). As well, a statement made during assessment is admissible for the purpose of determining whether the accused is unfit to stand trial, or (where the accused raises the issue, or following the verdict) whether the accused was not criminally responsible on account of mental disorder. With these latter exceptions there would still seem to be the potential for self-incrimination, since the circumstances of the offence would possibly be discussed in assessment.

Substantive Aspects of Fitness to Stand Trial

i) Defining "Insanity". The old Criminal Code referred to unfitness "on account of insanity" (s. 615[1]). "Insanity" was not defined in the Code. Historically, the term

has been applied in a rather broad fashion, incorporating, for instance, deaf-mutes and mentally retarded persons (Bull, 1965; Grubin, 1991; Schiffer, 1978). The problem is that mentally retarded or brain damaged persons may indeed be unfit to stand trial, but because their condition is untreatable they may never regain fitness and thus, under the law pre-Bill C-30, could face an indefinite detention under a warrant of the lieutenant governor.[7]

More recent Canadian case decisions have adhered to narrower, psychiatric conceptions of the term "insanity" (Rogers & Mitchell, 1991). In the 1978 Hughes case, the Alberta Supreme Court ruled that the accused, who had brain damage and a speech impediment, could not be considered unfit because the speech impediment (which prevented him from testifying) resulted from a head injury, not "insanity." In the 1988 Shupe case the Alberta Court of Appeal ruled that "natural imbecility" (the accused was a mentally retarded deaf-mute) was not equivalent to "insanity," for the purposes of determining fitness.

The fact remains, however, that in B.C. -- for example -- a number of persons with mental retardation or organic brain damage have been found unfit to stand trial in recent years (Coles, Veiel, Tweed, Johnson & Jackson, submitted; Hitchen, 1993).

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7. It may be that, to avoid this type of disposition, the courts apply a low standard of fitness when dealing with mentally handicapped persons (Bonnie, 1990). This is suggested by a current study of mentally retarded persons in the B.C. forensic psychiatric system (Hitchen, forthcoming), where the author found that retardation had to be severe before the fitness assessment process was invoked; in this study it was found that, in a three year period, only 22 persons who were mentally retarded (according to the diagnosis on the clinical file) were sent to F.P.I. for fitness assessment; further, in only eight of these cases was mental handicap the sole diagnosis -- in the other 14 there was a coinciding mental illness. The 22 cases represented a small fraction of the total number of fitness assessments.

Consequently, there remains the problem, in these cases, of arriving at an appropriate disposition for the accused persons. On the one hand, the Crown may be loath to agree to a stay of proceedings where the offence is of a serious nature; on the other hand, mentally handicapped accused persons may face lengthy periods of detention if declared to be unfit. Bill C-30 in fact puts "caps" on the length of time a person may be held as unfit, but the possibility of lengthy detention remains: the "cap" for summary offences is two years, and for indictable offences (short of those punishable by life imprisonment) ten years (although section 672.33 now states that the Crown must be able to make a prima facie case against the accused at least once every two years). Such detentions may in fact violate Charter of Rights protections, notably section 7 (right to life, liberty and security), section 9 (right not to be arbitrarily detained), section 11 (right to be tried within a reasonable time) and section 12 (right not to be subjected to cruel and unusual punishment).

In an earlier analysis the Law Reform Commission (1975) suggested that a case could be made for focusing the fitness rule "on the consequences, rather than the causes of unfitness" (p. 33), and to broaden the categories of disability that are relevant to the question of fitness; the Commission left unresolved, however, the definition of "insanity", and the problem of dispositions for untreatable unfit persons.[8]

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8. The U.S. Supreme Court addressed this problem in the 1972 Jackson v. Indiana decision, which involved the case of a mentally retarded deaf-mute being held as unfit to stand trial. The court ruled that an accused person could not be held for more than the "reasonable period" needed to determine whether there was a substantial probability that the person would attain the capacity (to stand trial) in the foreseeable future (although, as Steadman [1987] notes, the precise effect of this ruling is still unclear).

It is not clear whether these problems have been resolved with the passage of Bill C-30. The new Code provisions state that unfitness is to be "on account of mental disorder" (instead of insanity), with mental disorder defined as a "disease of the mind" (s. 2). It is possible that inclusion of the term "disease of the mind" may expand the definition of unfitness, to incorporate mental retardation, since the courts in Canada have previously defined "disease of the mind" in a broad fashion: see Cooper v. The Queen [1980]; as well, there is the fact that mental retardation is included in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (1987). It is also possible that since the dispositions for unfit persons, following Bill C-30, are now more flexible and may entail less deprivation of liberty (unfit persons may be granted a conditional discharge: see discussion later in this chapter), legal and clinical personnel may be more willing to extend the unfitness ambit to mentally retarded persons.

ii) Legal Standards. The old Code provisions stated that a fitness hearing could be ordered when it was felt that "the accused, on account of insanity, (was) incapable of conducting his defence" (s. 615[1]). The Code did not provide, for the purposes of clinical assessment, any more specific standards by which fitness could be tested. Some have argued that, without more explicit standards, there is greater potential for clinical decisions about fitness to be biased and idiosyncratic (Bagby, 1992; Roesch, Jackson, Sollner, Eaves, Glackman & Webster, 1984; Rogers, Gillis, McMain & Dickens, 1988; Webster, Menzies & Jackson, 1982, p. 40). In particular, it may be the case that some medical personnel, not understanding the legal definition of fitness,

confuse the issues of fitness and mental illness and thus automatically infer that a mentally disordered person must be unfit (Roesch & Golding, 1980).

The Law Reform Commission (1986) recommended that more specific criteria for determining fitness be included in revisions of the Criminal Code. This, in fact, has taken place. Section 2 now states that an accused may be unfit if unable to : (a) understand the nature or object of the proceedings; (b) understand the possible consequences of the proceedings, or (c) communicate with counsel. These three questions represent a distillation of previous case law decisions concerning fitness (Verdun-Jones, 1989).

The interpretation of the fitness criteria now in s. 2 was addressed by the Ontario Court of Appeal in its recent decision in Regina v. Taylor (1992). In this case the accused had originally been found unfit following a report from psychiatrists who testified that, while they considered the accused to be articulate, and aware of the nature and consequences of the proceedings, he should nevertheless be considered unfit to stand trial because "due to his paranoia he would not be able to trust counsel, nor to instruct them in his best interests" (Tollefson & Starkman, 1993, p. 42). The accused appealed this decision. In their ruling on the matter the Court of Appeal adopted a lower standard for fitness, by stating that an inquiry regarding fitness should only be concerned with whether the accused could recount to his or her counsel the facts relating to the offence:

> It is not relevant to the fitness determination to consider whether the accused and counsel have an amicable and trusting relationship, whether the accused has been cooperating with counsel, or whether the accused ultimately makes decisions that are in his or her best interests (Regina

v. Taylor, 1992, at p. 336).

Whether the inclusion of standards in the Criminal Code will mean greater consistency in fitness assessments remains to be seen. It should be noted, however, that the standards provide only provide a guide for assessors (although case law, such as the Taylor decision, will hopefully clarify the general standards). Further, as Roesch & Golding (1980) note, fitness is a relative, "open-textured" construct which is not easily reduced to a finite set of operational indicators; consequently, there is some question as to whether fitness standards for particular cases can ever be adequately reflected in statutes. As well, while fitness assessments may be idiosyncratic (Bagby, 1992), one cannot necessarily assume that the idiosyncrasy stems from a lack of knowledge of legal standards.

A number of more structured interviews and rating scales have been developed to help assess fitness to stand trial (Grisso, 1986; Melton, Petrila, Poythress & Slobogin, 1987; Ogloff, Wallace & Otto, 1991; Roesch & Golding, 1980; Rogers & Mitchell, 1991). Work in this area was pioneered, in the U.S., by McGarry and colleagues, who developed the Competency Assessment Instrument (CAI). The CAI is a semi-structured interview and rating scale that has been shown to have good reliability (agreement between raters) and validity (congruence with other measures of fitness) (Rogers & Mitchell, 1991). The Fitness Interview Test (FIT), a modification of the CAI, has been developed for use in the Canadian context by Roesch and colleagues (Roesch, Webster & Eaves, 1984). The FIT includes questions aimed at evaluating fitness as well as items pertaining to mental status. Research on the FIT

indicates reasonable reliability and validity figures (Roesch, Jackson, Sollner, Eaves, Glackman & Webster, 1984; Rogers & Mitchell, 1991). Despite these developments, it would appear that structured assessment instruments are not widely used in clinical settings (Rogers, Gillis, McMain & Dickens, 1988). Interviews conducted by the author (in 1992) with B.C. Forensic Psychiatric Services staff indicated that in fitness assessments clinicians would occasionally use the Competency Screening Test (CST); this test, developed in the U.S., is a rating scale consisting of 22 incomplete sentences concerning the trial and the relationship between the accused and their counsel. Rogers and Mitchell (1991, p. 103) suggest that "there appears to be considerable overlap between (the CST) and the Canadian standard (for fitness)." The author was told, however, that structured fitness instruments were not frequently used in the B.C. Forensic Psychiatric system (despite the recommendation, in a 1990 in-house report, that the FIT be routinely administered in all fitness assessments).[9]

Substantive Aspects of the Defence of Not Criminally Responsible on Account of Mental Disorder

The substantive aspects of the insanity defence in Canada are rather complex; the reader is referred, for example, to Verdun-Jones' (1989) and Coles & Grant's (1989) overviews of the subject. For the purposes of this study, however, the following may be noted: while there have been a number of changes to the Criminal

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9. It is not clear why this recommendation was not followed; it is not known, for instance, how strongly the administration pushed for change. With respect to the relationship between administration and the "front line", it might be noted, in this case, that the "front line workers" (fitness assessors) were psychiatrists, who may be used to having a certain degree of autonomy and discretionary authority.

Code concerning the procedural aspects of the insanity defence, the substantive aspects, that is, the criteria used in determining whether a person should receive the special verdict of (what is now called) Not Criminally Responsible on account of Mental Disorder (NCRMD), have not changed greatly (O'Mara, 1991; Verdun-Jones, 1989). The key condition that a person, due to disease of the mind, must be "incapable of appreciating the nature and quality of an act or omission, or of knowing that it was wrong" stays the same in the new Code (s. 16). Therefore, on the basis of statutory criteria, it cannot be said that it will now be "easier" or "harder" for an accused to be found NCRMD.

While the statutes have not changed substantially it should be noted that the 1990 Supreme Court decision in Chaulk v. The Queen changed the way a part of the statute is to be interpreted (Verdun-Jones, 1991b). As noted above, to be found not guilty by reason of insanity (now NCRMD) the accused must have been incapable of appreciating the nature and quality of an act or omission, or of knowing that it was wrong. Previously, the Canadian Supreme Court had ruled, in Schwartz v The Queen (1976), that "wrong" should be interpreted more narrowly as legally wrong. As Verdun-Jones (1991b, p. 22) notes, this interpretation:

> exclud(ed) from its benefit those mentally disordered individuals who, even though they knew that their actions were contrary to the law, nevertheless firmly believed, for example, that they were acting on divine instructions and, therefore, would earn the moral approbation of their fellow citizens for their conduct.

After Chaulk, however, it would appear that "wrong" is to be interpreted more broadly as morally wrong (although there is some debate as to whether the old test of

"legally wrong" has been substituted with, or is to be used in addition to, the new test of "morally wrong": see Tollefson & Starkman [1993, p. 26]). The test, articulated in Chaulk, is whether the accused is capable of knowing that the offence would be regarded by society at large as being morally wrong; the standards applied would be the ordinary moral standards of reasonable men and women, not the accused's personal moral standards (Verdun-Jones, 1991b). On the basis of this case decision, one may conclude that the insanity standard in Canada has been broadened somewhat.

There have been a few changes in terminology in the new Criminal Code, which are as follows. In the new Code, the term "insanity" has been replaced by "mental disorder" (s. 16), and mental disorder is defined as a "disease of the mind" (s. 2). This might seem to be a cosmetic change in that "insanity" in the old Code was also defined as a disease of the mind; it is notable, however, that "disease of the mind" has been retained, since judicial decisions in Canada, notably in Cooper v. the Queen (1980) and Rabey v. the Queen (1981), have held that "disease of the mind" (and thus, "mental disorder") is to be treated as a legal, rather than a medical concept (Verdun-Jones, 1989). Empirical studies have found that the majority of insanity acquittees in Canada suffer from major psychotic disorders, such as schizophrenia (Golding, Eaves & Kowaz, 1989; Hodgins, Webster, Pacquet & Zellerer, 1989; Rice & Harris, 1990). It should be noted, however, that the legal definition of insanity has been broadly framed: in Cooper (1980) Dickson J. of the Supreme Court of Canada stated that:

> "disease of the mind" embraces any illness, disorder or abnormal condition which impairs the human mind and its functioning, excluding,

> however, self-induced states caused by alcohol or drugs, as well as transitory mental states such as hysteria or concussion.

Judicial opinion has held that conditions such as personality disorder may indeed constitute a disease of the mind (Coles & Grant, 1989; Verdun-Jones, 1989); whether such conditions are sufficient to render the accused "incapable of appreciating the nature and quality of the act, or knowing that it was wrong" is, however, another question.

A second change is that in the old Code "insanity" could incorporate "natural imbecility", whereas in the new Code natural imbecility has been left out.

A third change in wording in the new Code is that the phrase "not guilty" has been replaced by "not criminally responsible". This is apparently to rectify the confusion over the fact that previously persons were found not guilty even though they had committed the act; now the Code explicitly recognizes that an accused found NCRMD committed the act (s. 672.34).

Finally, it may be noted that the old section 16(3), which concerned "specific delusions", has been eliminated. This is not a major change in that 16(3) was rarely used and was in fact considered to be redundant in light of the old section 16(2) ("incapable of appreciating...") (Coles & Grant, 1989; Verdun-Jones, 1989).

Dispositions.

i) Review Boards. One of the more important changes in the Criminal Code after Bill C-30 concerns the role of the review board. Under the old legislation, the disposition of persons found to be unfit to stand trial or not guilty by reason of insanity was re-assessed at least once a year by a board of review. The existence of

a review board was not in fact required by the Code, which stated only that "the lieutenant governor of a province may appoint a board of review... "(s. 619). Review boards could only make recommendations about a person's release or continued detention: these recommendations had to be approved by the lieutenant governor of the province, which in most cases meant the provincial cabinet. The problem here was that the cabinet could be motivated by public opinion, so that, in some politically sensitive cases, it could veto the release of a patient even if the "sanity" of the person had been regained (Coles & Grant, 1990; Harris, Rice & Cormier, 1991). Further, while patients could state their cases before the review board, they did not have any access to the cabinet, so that, in many instances, this body did not have to account for its decisions.

The courts in Canada have ruled, in a number of cases, that there must be fairness in the review process; that is, the boards must provide the accused with certain procedural protections, and the Lieutenant Governor must consider the board's recommendations (O'Mara, 1991). For instance, the Ontario Court of Appeal ruled in Abel (1981) that the Review Board was under a judicially enforceable duty to act fairly in making its decisions. In the 1986 Nova Scotia Supreme Court ruling in Jollimore, the court indicated that, while the Lieutenant Governor was not bound by the recommendations of the review board, he or she was under a duty to act fairly and to receive and consider the board's recommendations. In Grady v. the Attorney General of Ontario (1988) the court ruled that recommendations coming out of a review hearing could only be relied on by the Lieutenant Governor to the extent that they

were the product of a fair hearing; further, the Lieutenant Governor could not impose a more serious restriction than that proposed by the board without giving the accused a hearing.

Under the new Code review boards are now mandatory (s. 672.38). Further, the role of the cabinet and/or lieutenant governor -- in considering review board recommendations -- has been eliminated. This will have the effect of transforming the review board from an advisory body to an independent tribunal (O'Mara, 1991). As well, the Code now provides, more explicitly, a number of procedural protections for the accused (see below).

It is notable that the new Code gives the review board considerable leeway in determining its own practices and procedures (s. 672.44).

ii) Disposition Hearings. Prior to Bill C-30 review board hearings in B.C. were generally informal and non-adversarial in character (O'Mara, 1991). In attendance would be board members, a hospital representative (who in B.C. was usually a "nurse case coordinator"), the accused and (sometimes) counsel for the accused. The board was essentially left to determine its own procedures.

Under provisions in the new Criminal Code (sections 672.45 to 672.53) review board hearings are now more complicated, with matters of due process more explicitly addressed. It is notable that now:

> Any party may adduce evidence, make oral or written submissions, call witnesses and cross examine any witness called by any other party and, on application, cross-examine any person who made an assessment report that was submitted to the court or review board in writing. (s. 672.5[11].)

Further, section 672.5(12) states that any party may request the review board chairman to compel the attendance of witnesses; this implies that psychiatrists, who previously never attended hearings in B.C., could be asked, for instance, to appear to justify their recommendation to deny the release of a patient.

The Code also now states that the accused has a right to be present at the hearing. Further, the accused, his or her counsel, and other involved parties are entitled to copies of the assessment report and "any other written information before the court or review board about the accused that is relevant to making a disposition" (s. 672.51). Thus, the right of access to file material is now explicitly addressed, whereas previously the Code was silent on this matter.[10] (It was suggested to the author, by Forensic Services staff, that the previous practice had been for the accused to have extremely limited access to file material; it would be fair to say that the prospect of greater access by the accused to this material was causing some trepidation among clinical staff.) The right of the accused to be present and to inspect written material is limited, however, notably if the board feels that this would "seriously impair the treatment or recovery of the accused."

O'Mara (1991, p. 76), in addressing the consequences of the new provisions, suggests that the potential "increase in the number of parties and counsel will have a tendency to exponentially increase the length and complexity of the hearings process" and that "the hearings are unlikely to remain non-adversarial in nature."

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10. Although case law had previously established a limited right of access (see, for instance, the Ontario Court of Appeal decision in Re Abel et al and the Advisory Review Board [1980]).

iii) Public Access to Hearings. The old Criminal Code was silent on the matter of public access to review hearings. In the new Code, s. 672.5(6) states that members of the public may be excluded from attending hearings "where the court or Review Board considers it to be in the best interests of the accused and not contrary to the public interest." The issue of public access was addressed in the 1993 B.C. Supreme Court decision in Blackman v. B.C. Review Board and Attorney General of B.C. The petitioner Blackman, who was applying for an absolute discharge after having been found NGRI in 1983, had argued that media coverage leading up to his hearing had caused him psychological stress and anxiety, and that the media should consequently be excluded from this hearing. A lawyer for the Attorney-General's office had argued that "the public had a vital interest in seeing how the justice system deals with a man whose mental state rendered him not criminally responsible for killing his family 10 years ago" (Hall, 1993, p. b2). Justice Brenner of the B.C. Supreme Court concurred, noting that "Parliament has properly made public interest the paramount consideration," and on June 16, 1993, dismissed Blackman's petition.

iv) Criteria for Determining Discharge. In the old Code, section 619 contained the criteria by which a person held in custody under a warrant of the lieutenant governor could be considered for discharge. For unfit persons it was "whether....that person has recovered sufficiently to stand trial." For persons found not guilty by reason of insanity it was "whether....that person has recovered and, if so, whether in (the board's) opinion it is in the interest of the public and of that person" to recommend an absolute or conditional discharge.

One can note that the wording in this passage is rather vague, i.e. what does "interest of the public" mean?[11] Further, the primary consideration is (apparently) the mental state of the accused: "whether that person has recovered". In the case of Lingley v. New Brunswick Board of Review (1973) it was determined that "recovery" could be interpreted (by the board) as meaning "full recovery."

Coles and Grant (1990, p. 244) suggest that in B.C.[12] the hospital staff, review board and cabinet have each in practice applied somewhat different criteria in NGRI cases: for clinicians "there is an emphasis on psychiatric criteria and the welfare of the patient", for the review board their primary concern is "the individual's dangerousness....and protection of the public", and for the cabinet, decisions are dictated by "public opinion."

There is evidence that in Canada persons found NGRI have been detained longer than should be needed to restore their mental state, and that length of time in custody is largely a function of the seriousness of the offence (notwithstanding the fact that they are "not guilty") (Golding, Eaves & Kowaz, 1989; Harris, Rice & Cormier, 1991). Harris, Rice & Cormier (1991) point out that there should be no necessary

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11. The Supreme Court of Canada ruled in Morales (1992), with respect to bail decisions, that "public interest" as a release criterion was too vague and imprecise, and thus in violation of the Charter of Rights (wherein s. 11(e) guarantees the right not to be denied reasonable bail without just cause).

12. Each provincial review board may adopt a different "style" of operation (Coles & Grant, 1990; O'Mara, 1991) -- a reflection, no doubt, of the discretionary leeway granted to the boards. It may also be noted that while the old Criminal Code allowed the lieutenant governor of a province to appoint a review board, in B.C. the Review Board was not appointed under the Code, but rather was established by an order-in-council.

relationship between offence seriousness and time in detention, unless one could argue that more severely disordered persons commit more serious offences, an idea for which there is little supporting evidence. It would seem, then, that discharge decisions are based on other factors, such as political considerations.

In the new Code, the criteria to be used in determining dispositions of persons found unfit or not criminally responsible on account of mental disorder are found in section 672.54. There it is stated that the board "shall take into consideration the need to protect the public from dangerous persons, the mental condition of the accused, the reintegration of the accused into society, and the other needs of the accused....." Specifically in the case of persons found NCRMD the Code now states that "where....in the opinion of the court or review board, the accused is not a significant threat to the safety of the public, by order, direct that the accused be discharged absolutely" (emphasis added).

One can see that the criteria are somewhat more explicitly stated in the new provisions. Crucially, it would also seem that the primary consideration is now dangerousness, as opposed to the (apparent) emphasis on mental state and need for treatment in the old Code (O'Mara, 1991).

This interpretation of section 672.54 (discharge decisions based upon perceived dangerousness) was affirmed in the important 1992 B.C. Court of Appeal decision in Orlowski v. Attorney General of B.C. In Orlowski, the opinion was that the Board, in determining dispositions for persons found NCRMD, must first deal with the issue of "significant threat", before applying any other criteria (such as paternalistic

concern); further, the distinction must be made between "threat" and "significant threat". Where the Board found that the accused was not a significant threat, he or she would be discharged absolutely. As well, the Board's decision on significant threat must be made explicit in a report to the accused; as Chief Justice McEachern stated: "fairness requires the accused to be given a specific finding with explanatory reasons on this most important question." Without such manifest reasoning by the Board, dispositions appealed by the accused would (it was suggested) in most cases be referred back to the Board "with instructions that it make findings on these questions."

It is notable, however, that the Orlowski decision leaves the Board with considerable discretion in restricting absolute discharges. First, it was held in Orlowski that "threat" could mean "potential for future threat", (not just imminent threat), as in the case of a person who could become a significant threat if that person stopped taking prescribed medications. Second, absolute discharge was dictated only when the Board's opinion was that the accused was not a significant threat; where the Board was uncertain as to this issue, then an absolute discharge need not be ordered. This interpretation of the new statute is significant in that "protection of the public" is pulled back strongly into the release decision.

v) Court may make Disposition. One change in the new Code is that now the initial disposition of a person found unfit or NCRMD can be made by the court itself. The Law Reform Commission (1975) had in fact earlier suggested that the court (having recently heard all the evidence) was in the "best position" to assess appropriate dispositions. Dispositions made by a court are to be in effect for up to 90

days, after which the accused comes under the jurisdiction of the review board. If the court elects not to make a disposition, then the review board must make one within 45 days.

vi) Terms of Disposition. The old Criminal Code did not specify the sorts of dispositions available for persons found unfit or NGRI; this was left to the discretion of the review board. While the law did not require the detention of persons found unfit or NGRI (s. 617), in B.C. such individuals were always initially kept in "strict custody" at the Forensic Psychiatric Institute.

Unfit persons generally remained in custody until found fit and returned to court. While periods of detention as unfit could vary (Verdun-Jones, 1981), a study by Roesch, Eaves, Sollner, Normandin & Glackman (1981) conducted in B.C. in the late 1970s found an average duration of six months.[13] The Law Reform Commission (1975, p. 41)) recommended "that a finding of unfitness not always lead to detention and that there be a range of dispositional alternatives, some involving little or no deprivation of individual freedom."

Persons found NGRI in B.C. would gradually work their way through several levels of custody, for instance being given hospital grounds privileges, then day passes to the community, then conditional discharges (to live in the community and report to an outpatient clinic) and ultimately (depending on their compliance) an absolute discharge. Persons held in custody as NGRI were (prior to Bill C-30) referred to as

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13. There have been some extreme and unjustifiable cases, such as that of Emerson Bonnar, the New Brunswick man held for 16 years as unfit following an alleged purse snatching (Savage & McKague, 1987).

"Order-in-Council" cases, while those given conditional discharges were referred to as "Modified- Order-In-Council" cases. The situation in Ontario was apparently similar (O'Mara, 1991), with the diminishing levels of custody referred to as "loosened warrants."

Contrary to public perception, an insanity defence did not represent "getting off the hook", in that the subsequent time in detention was often longer than that for persons convicted and incarcerated for similar offences (Harris, Rice & Cormier, 1991). A study in B.C. found that the average individual spent about nine and one half years in supervision (i.e. in custody plus time under supervised discharge) after being found NGRI (Golding, Eaves & Kowaz, 1989).

By contrast, the new Criminal Code states that dispositions that are made for persons found unfit or NCRMD shall be the "least onerous and least restrictive to the accused" (s. 672.54). Since the dispositional options are somewhat different for unfits vs. NCRMDs, these shall be discussed separately.

For a person found unfit, this individual may be found fit at a subsequent hearing, and may thus be sent back to court. If he or she is still unfit, the review board has three options: the person may be detained in a hospital, given a conditional discharge, or given a treatment order. A treatment order is only for the purposes of restoring fitness, and is for a maximum of 60 days. The treatment ordered apparently does not have to be on an inpatient basis.

For persons found Not Criminally Responsible on account of Mental Disorder there are three options: the persons may be discharged absolutely, discharged with

conditions, or detained in a hospital. Treatment orders cannot be given for NCRMD cases (only unfits).

Reviews of dispositions, for both unfits and NCRMDs, must be held at least once a year (s. 672.81), or more frequently at the request "of the accused or any other party" (s. 672.82).

It is notable also that for persons found unfit the new Code provisions dictate that the prosecution must be able to make a prima facie case against the accused every two years, or more frequently upon the application of the accused; if the prosecution is unable to do so, the accused is to be acquitted (s. 672.33).

vii) Treatment in Disposition. The normal mechanism for involuntary psychiatric treatment in B.C. is certification under s. 20 of the Mental Health Act. However, for the special category of persons found unfit to stand trial or (what was previously called) not guilty by reason of insanity, involuntary treatment could be given under s. 25.1 of the Mental Health Act, where it is stated that such persons "shall receive care and psychiatric treatment appropriate to (their) condition as authorized by the director"; that is, in such cases involuntary treatment could be given without certification. (This special provision did not exist in all provinces: see Robertson [1987].) Presumably, treatment under this provision will continue in forensic settings in B.C. after Bill C-30.[14]

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14. It should be noted, however, that s. 25.1 would appear to be inconsistent with Charter of Rights guarantees, in that no guidelines or criteria (such as dangerousness) are given to help determine whether involuntary treatment is necessary; rather, treatment is automatic. Having said that, it should be noted that Charter challenges to mental health legislation in Canada have, to date, been largely unsuccessful (see discussion of McCorkell decision,

The matter of involuntary treatment is made more complicated with the introduction (noted above) of the treatment order, for unfit persons, in the Criminal Code. There are several problematic aspects of this provision. First of all, ordering treatment under this provision requires the clinician to make a prediction, that treatment "will likely make the accused fit to stand trial within a period not exceeding 60 days" (s. 672.56(2)(b)); clinicians may in fact be reluctant to make these sorts of predictions. Secondly, authorizing treatment under the federal Criminal Code would seem to represent a jurisdictional infringement, since health care in Canada is normally considered to be under the authority of the provinces. Thirdly, the provision does not take into account the matter of competency to refuse treatment: in provinces such as Ontario involuntary treatment following civil certification may not be given until the question of the patient's competency has been resolved; treatment cannot be given to a competent patient without his or her consent (Verdun-Jones, 1988). Consequently, sidestepping the requirements of the provincial statutes and giving treatment under the Code provision would appear to be a practice that violates the Charter, notably s. 7, which guarantees the right to life, liberty and security of the person, although it may be argued that the benefit of treatment -- being made fit -- outweighs the risk of harm (applying a Charter s. 1 analysis). In B.C. the situation is different from Ontario: certified persons are "deemed to have given their consent" (s. 25.2 of the Mental Health Act) and may not refuse treatment; further, as noted

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footnote 10, Chapter One; see also Robertson [1987]).

above, clinicians are given broad discretion under the Mental Health Act in the involuntary treatment of persons found to be unfit or NGRI/NCRMD. Thus, in B.C., concerns about the use of the treatment order may be irrelevant in that treatment can always be authorized under the provincial statute;[15] this situation may change if the B.C. Mental Health Act is amended to be more similar to the Ontario legislation, or if s. 25.1 is ruled invalid.

viii) Capping. Previously the lengths of disposition for unfits or NGRIs (under warrants of the lieutenant governor) were indeterminate. Under the new Criminal Code they have been "capped": if the charge is murder (or any other offence where the minimum punishment is life imprisonment), the cap is life; for certain designated indictable offences (see schedule to Part XX.1), the cap is ten years or the maximum period the accused could be sentenced for the offence, whichever is less; for other offences, the cap is two years or the maximum sentence, whichever is less.

An exception to "capping" concerns persons found NCRMD whose charge was a "serious personal injury offence" (a sexual assault or other crime of violence). In such cases the prosecutor may ask that the court find the person a "dangerous mentally disordered accused", in which case the court may increase the cap to a maximum of

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15. The use of the treatment order was not specifically examined in the present study. It was suggested to the author, however, in an August 1993 conversation with a Forensic Services staff person, that ordering treatment of persons under s. 25.1 of the Mental Health Act, which had been done routinely before Bill C-30, was now being approached with more caution; this was because, apparently, psychiatrists sensed that this provision was inconsistent with the restrictions on involuntary treatment in disposition dictated by the Criminal Code.

life (s. 672.65).[16]

The fact that persons found NCRMD may now be given early discharges under the new law has, predictably, created some controversy. The changes in the law may fuel the public perception that the insanity defence "is a loophole that allows too many guilty people to go free" (Ogloff, Schweighofer, Turnbull & Whittemore, 1992). This in fact seems to be the slant taken by the press, with newspaper headlines announcing, for instance, "Woman who drowned daughter allowed to go home" (Pemberton, 1992), and "Woman free four months after killing her son" (Canadian Press, 1992).

ix) Appeals. Under the old Criminal Code, persons found unfit or NGRI could appeal, to the court of appeal, against the initial verdict made by the court (s. 675). There was no provision, however, for appealing subsequent decisions made by the review board that the person was still unfit or NGRI (and therefore, should still have limits placed on their freedom). This is different than the civil commitment situation, where provision for appeal of review panel decisions is contained in some provincial mental health acts (Robertson, 1987).

In the new Code, this situation has been changed. Section 672.72 now states that "any party may appeal against a disposition or placement decision made by a court or review board to the court of appeal". It should be noted, however, that the appeal court judge is given considerable discretionary powers as to how he or she may respond to the appeal (sections 672.76 to 672.8).

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16. The criteria applied in this section are essentially the same as those used in the "dangerous offender" provisions.

Implications of Bill C-30

The changes to the Criminal Code under Bill C-30 are complex and cover many different aspects of the assessment, management and disposition of mentally disordered offenders. Nonetheless, it seems fair to say that the intention of the new provisions is to provide more procedural safeguards and better protect the civil rights of accused persons in the forensic psychiatric system. In particular, there has been an attempt to redress some of the aforementioned concerns about arbitrary assessment, self-incrimination, inordinate time in remand, unnecessary detention, indeterminate dispositions, lack of procedures in hearings, and lack of an appeal process.

At the same time, in preliminary discussion with forensic clinicians and administrators, some concern was expressed about the new demands that may be placed on the system as a result of the changes in the law. In particular, as will be detailed below, there was concern that the Bill C-30 changes could lead to an increase in the requests for forensic assessment, and could lead to a more strained, time-consuming relationship with the review board.

The main implications of Bill C-30, for the purposes of this study, are reviewed below.

Greater Provision for Postponing the Issue of Fitness. As noted above, the new Code provisions permit the question of fitness to be postponed to a later point in the court proceedings. There is some doubt, however, as to whether this option will be used, based on an historical reluctance of court officers to postpone the issue.

Purpose of Pre-Trial Assessments Clarified and Narrowed. The new Code

provisions spell out more explicitly the purpose of the pre-trial assessment, e.g. "to assess fitness". Standardized referral forms have been introduced in the new Code, and in B.C. the in-house referral forms have been changed to reflect the new legislation. Notably, the B.C. forms provide fewer options for the referring person than was the case previously. This means, on the face of it, that court orders in B.C. (a) will spell out explicitly the service to be provided, and (b) will ask for fewer services. By extension, this should mean that psychiatric reports will be less "expansive".

Fitness Assessments to Conform to Standards in the Code. The old Code provisions contained no standards by which to judge an accused person's fitness. The new Code provides some standards, and consequently it may be that fitness assessments will now be less idiosyncratic (Rogers, Gillis, McMain &Dickens, 1988).

Duration of Pre-Trial Assessments to be Shorter. The new Code provisions state that fitness assessments are to be only five days in duration, although there is discretion for extending this period. Since a large proportion of pre-verdict assessments concern fitness (Rogers, Gillis, McMain & Dickens, 1988), this should mean that, in general, accused persons will be spending less time in pre-verdict assessment. It is conceivable, however, that some clinical staff will feel that the shorter time frame means that assessments now will be less thorough. One other implication is that five days may be insufficient time to restore fitness (where necessary) by treatment.

Assessments may now be Out of Custody. The Code now indicates a

presumption against the detention of persons undergoing assessment, although discretion is given to the court in determining this matter. Whereas previously 30 day psychiatric remands were done at F.P.I., now more assessments should be done at outpatient clinics.

Statements made in Assessment now "Protected". There is now, apparently, greater protection against self-incrimination during pre-trial assessments with the provision for "protected statements".

Number of Assessments will Increase. It is possible that there will be an increase in requests for court-ordered assessments following Bill C-30. Several factors may contribute to this. First, new reasons for assessment have been created in the Code; namely, where a person has been found unfit or NCRMD, to determine the appropriate disposition (before there was no discretion in this matter: initial disposition was always strict custody). There is also provision for assessment to determine the feasibility of a hospital order (s. 736.11), although at this time hospital orders are not in effect. Secondly, assessments to determine criminal responsibility may increase if, because of Bill C-30, the defence of NCRMD becomes more popular (see below). Thirdly, fitness assessments may increase if they are perceived to be now less onerous, because of their shorter duration and the possibility that they may be done out of custody.[17]

Nature of Review Process to Change. The review board is now more of an

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17. Of course, the requests for assessment may increase for reasons having nothing to do with Bill C-30, e.g. the increasing number of mentally disordered persons in the community.

independent tribunal, and greater attention has been given to the due process rights of the accused. It has been suggested that the hearings may become more adversarial in nature, and that the length and complexity of the process will increase (O'Mara, 1991). Attending to review board requests may require more time from B.C. Forensic staff.

Less Restrictive Dispositions of Persons found Unfit or NCRMD. The Code provisions now state that dispositions shall be "the least onerous and least restrictive to the accused." Further, persons found NCRMD are to be discharged absolutely where, in the opinion of the review board, they are "not a significant threat to the safety of the public." Consequently, one might expect to find persons found NCRMD being given conditional and absolute discharges more frequently, and earlier, than was the case previously.

The Defence of "Not Criminally Responsible" is a more Attractive Option. If the consequences of being found NCRMD are perceived to be less onerous, a possible result will be that this particular defence (previously referred to as the insanity defence) will now be used more frequently.

To understand this, the reader should be aware that historically in Canada the insanity defence has been raised relatively infrequently, and usually for more serious crimes (Rice & Harris, 1990; Rogers & Mitchell, 1991). This was because, with the possibility of an indeterminate detention in a mental hospital if found NGRI, defence counsel (and the prosecution) did not feel it was in the interests of the accused to raise the defence in most cases. An Ontario study by Harris, Rice & Cormier (1991) found

that, on average, persons found NGRI did not spend any less time in detention than persons convicted of the same offence; in fact, for lesser offenses, persons found NGRI could expect to serve considerably longer in detention. Coles & Grant (1989, p. 181) suggest that "it is unlikely that a defence counsel will intentionally seek a verdict of not guilty by reason of insanity for any offence for which the offender may be sentenced on conviction to imprisonment for a period of less than 10 years."

In his B.C. survey, Ogloff (1991) found that for minor offences, where in theory a person might have qualified for an insanity defence, the practice was often to have charges stayed and the person diverted into the mental health system; he also found that, on the other hand, a number of the clinical and legal personnel surveyed felt that the insanity defence should not be limited to certain types of crimes. Further, Ogloff (1991) gathered the perception from his respondents that after Bill C-30 the insanity defence would be raised more frequently for lesser crimes. It may be noted from Ogloff's study that the Crown counsel interviewed were not altogether pleased at the prospect of the NCRMD defence being raised frequently.

The contention that the type of crime for which an insanity defence is raised may change if the consequences become less onerous receives some empirical support from a different jurisdiction. Packer (1985) studied the effects of a change in the law in Michigan, concerning persons found NGRI, which ended the mandatory incarceration of insanity acquitees. He found that after the change in the law more persons requested insanity evaluations, and more persons were found NGRI for less serious (nonviolent crimes), although the total number found NGRI did not change

significantly.[18]

Finally, in preliminary discussions with Forensic Services staff, the impression was given that the NCRMD defence -- with its less onerous consequences -- would now attract more "malingerers", that is, persons feigning mental disorder to escape criminal sanctions.

In sum, the implications of the Criminal Code changes reviewed above formed the basis of the questions that were addressed in studying the first year of the implementation of Bill C-30 in B.C. For each issue the logic was to attempt to see if the intentions of the law would be -- or were being -- realized, and to elucidate any "secondary consequences" of the new provisions. A detailed description of the method is the subject of the following chapter.[19]

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18. The results of this study are somewhat difficult to interpret, since four distinct legislative changes were brought in at the same time.

19. One new provision that has not been discussed so far is the hospital order; courts may, under the new Criminal Code, order that the initial part of an offender's sentence (up to 60 days) be served in a treatment facility (presumably a forensic hospital) if the accused becomes acutely mentally disordered at sentencing (s. 736.11). This provision was not in effect at the time this study was undertaken, so it was not possible to assess (anecdotally, or quantitatively) its potential impact. One can imagine, however, that the availability of the hospital order will lead to an increase in admissions to the Forensic Psychiatric Institute, given the relatively large number of mentally disordered persons in the local court system (Gingell, 1991; Hart & Hemphill, 1989). There is evidence from England that the advent of the hospital order has in fact strained existing treatment resources in that country (Verdun-Jones, 1989) (although the English hospital order, unlike the Canadian, results in the accused person spending the entire duration of their sentence in hospital).

Chapter Four

Methodology

General comments on the Method

This study is an examination of the first year of the implementation of Bill C-30 in British Columbia. An attempt was made to assess the impact of the new law by looking at a number of areas where previous practices were expected to change because of the new provisions. The study utilized both archival data and interviews to accomplish this task. Before getting into the particulars of the method, it is necessary to make some more general comments on the difficulties inherent in this type of study.

To begin with, the new legislation is rather complex, and affects a number of different aspects of legal and forensic psychiatric practice. Because of this, it was necessary in this study to look at a number of separate issues relating to the new law.

A second problem concerns the timing of this study. The study looks only at the first year of the new law. Because of this, some of the longer term effects of the law obviously cannot be examined. In fact, there is some suggestion, from previous research, that the first year of a new law may be an "atypical" year, because legal practitioners and others presumably need some time to grasp the new provisions and their implications (Luckey & Berman, 1979; Packer, 1985). Indeed, in the present study it was found, for a number of the issues examined, that interview subjects had had limited experience with the new provisions; this meant that their comments were, in some instances, speculative, drawing from experience with the old system. Despite these problems, it can be said that the present study did uncover evidence of changing practices even in the first year -- both from archival and interview

sources. It is hoped, therefore, that this study identifies some of the key issues and provides a "baseline" for future work.

A third problem is one common to other "legal impact" type studies, and naturalistic studies in general: the question of internal validity (see Cook & Campbell, 1979; Lempert, 1966; Ogloff, Schweighofer, Turnbull & Whittemore, 1992; Palys, 1992; Roesch & Golding, 1985). Briefly stated, if a new law is followed by a change in administrative practices, it is difficult to say whether the law "caused" the changes or whether some other factor (unaccounted for) produced the change. For instance, it may be that the coincident arrival of new personnel, who have a different way of doing things from their predecessors, or other changing factors, constitute the key independent variables, above and beyond any effect of the law per se.

There are two (overlapping) strategies for trying to determine whether or not the presumed independent variable is having an effect in evaluation studies (Campbell & Ross, 1968; Cook & Campbell, 1979). One is the use of a time series design; the second is to use alternate data sources to try to rule out rival explanations for changes in the dependent variable.

A time series design involves an examination of a quantitative variable over a (relatively) long period of time. Multiple data points are used to avoid the problems involved in making inferences from single "before and after" measurements. One problem, for instance, is the possibility that the single before or after measure was atypically high or low, meaning that one cannot reasonably draw too many conclusions about long-term effects. While time series designs may provide evidence of changing patterns, they cannot rule out

internal validity problems; that is, they can give an indication that there has been a change in the dependent variable, but not necessarily the cause of the change (Cook & Campbell, 1979).

In the present study, several quantitative dependent variables were examined; these were: (i) duration of inpatient assessments, (ii) number of assessments, (iii) number of assessments performed out of custody, (iv) number of assessments where mental state at time of the offence was examined, (v) number of persons found NCRMD, (vi) number of persons found NCRMD or unfit and given an initial out of custody disposition, (vii) number of absolute discharges of persons found NGRI/NCRMD, (viii)proportion of fitness assessments making reference to particular fitness standards and (ix) proportion of pre-trial assessments making reference to particular clinical and extra-clinical issues. In each case, it was hypothesized that Bill C-30 would produce a change in these variables. Data were gathered from the first year of the new law, and, where possible, compared to data from preceding years, giving a preliminary picture of the (presumed) impact of Bill C-30. However, using a time series to analyze these data was problematic, for several reasons.

First of all, in some cases the law resulted in a new practice (variables iii and vi above), so that there was no "before" data for comparison.

Secondly, the "after" period in the present study -- one year -- is likely too short for a meaningful time series analysis; in effect, the aggregated data from the first year represent a single data "point" (it has been suggested, as a rule of thumb, that a minimum of 50 data points are needed [Cook & Campbell, 1979]). There is the possibility of disaggregating the data from years to months, to provide more data points; this, in fact, was attempted with

"number of assessments" (variable ii above). However, disaggregating data in the case of "duration of assessments" (i above) creates difficulties, because the mean duration of assessment is a variable that can be skewed by a few extreme values; the instability of this statistic is less a problem in large aggregations of data (i.e. a year) but is exaggerated in small (monthly) aggregations to the extent that a monthly time series, in the case of the present study, was not particularly meaningful.

A third problem concerns the length of the "before" period. In two cases (variables v and vii above) information going back a number of years was obtained relatively easily, through the Forensic Service's Patient Information System. However, in the case of variables viii and ix (above) manual content analysis of files was required; because of the "labour intensiveness" of this method it was simply not possible to cover more than a single year in the "before" period, meaning that, for these variables, a simple "before and after" comparison is presented.

Finally, the use of a multiple time series design (comparing a jurisdiction affected by an intervention with one not affected, as a "control" -- see, for example, Centerwall [1989]) is ruled out in the case of Bill C-30, since this is a federal law that affects all citizens in all Canadian jurisdictions.

The second strategy for trying to assess the impact of a new law is to try to discount alternative explanations for any changes that have -- or have not -- followed the implementation of the law. To help accomplish this, the present study used interview data to complement, and help clarify, the archival data. It was felt that the interview information was invaluable for this purpose, particularly in identifying areas where the law may not show

much of an impact (because of the discretion allowed the practitioners).

Notwithstanding the methodological problems, results from the interviews and archival analysis gave, in a number of instances, a reasonably good indication that practices concerning the handling of mentally disordered offenders were changing as a result of Bill C-30, particularly when interview results were congruent with archival data. Several of the interview questions produced a clear consensus from all parties interviewed that practices were changing, and in some instances the quantitative data indicated a relatively abrupt change from previous patterns. As well, in some cases practices were started after Bill C-30 (e.g. outpatient fitness assessments) that had simply never previously occurred. It is conceded, however, that for some of the issues examined, the results can best be termed "ambiguous", and needing further time and study for clarification.

Issues Addressed in the Study

In assessing the impact of Bill C-30 several different aspects of the new law were examined. The areas picked for examination were ones where changes in practice due to Bill C-30 might be expected, based on an understanding of previous practices and the apparent intent of the new law (see Chapter Three). The data sources used were (a) archival (i.e. official records and file information) and (b) interviews with legal and clinical personnel. It was hoped that all the changes being assessed could be verified with archival data; a few of the questions, however, refer to unrecorded activities at court or review hearings, and in these cases only interview results are reported. It was hoped that, in the absence of archival data, the interview results would provide useful qualitative data. As noted above, the two data sources were designed to complement one another.

The research issues, stemming from the "Implications of Bill C-30" given at the end of Chapter Three, are listed below. It should be noted that, because of the exploratory nature of the study, they are not expressed as hypotheses to be proven or disproven. In each case the data source used in the investigation is given.

Issue Number One: Postponing addressing the question of fitness at court. Data source: Interviews.

Issue Number Two: Clarifying and narrowing the focus of pre-verdict assessments. Data sources: Interviews and archival.

Issue Number Three: Getting fitness assessments to conform to legal standards. Data sources: Interviews and archival.

Issue Number Four: Shortening the duration of fitness assessments. Data sources: Interviews and archival.

Issue Number Five: Performing fitness assessments out-of-custody. Data sources: Interviews and archival.

Issue Number Six: Protecting accused persons from self-incrimination during psychiatric assessment. Data source: Interviews.

Issue Number Seven: Increasing numbers of court-ordered assessments. Data sources: Interviews and archival.

Issue Number Eight: More procedural protections for mentally disordered accused persons in the Disposition Review Process. Data source: Interviews.

Issue Number Nine: Less restrictive dispositions for persons found to be unfit or not criminally responsible. Data sources: Interviews and archival.

Issue Number Ten: Greater utilization of the "not criminally responsible" defence. Data source: Interviews and archival.

Interviews

i) The interview subjects. Thirty mental health and legal professionals, who were presumed to have special knowledge of the mental disorder provisions in the Criminal Code, were interviewed for this study. The thirty can be grouped (roughly) into four categories: (a) B.C. Forensic Psychiatric Services staff (fifteen); (b) Crown Counsel (seven); (c) defence lawyers (seven), and (d) Review Board official (one). The intent here was to ensure the representation of the main parties involved in the forensic psychiatric system, i.e.: clinical staff, prosecution, defence and Review Board. One obvious omission from this list is judges; the author was informed by several faculty persons prior to the study that it was exceedingly difficult to access judges in B.C. for research purposes,[1] and so this particular professional group was not approached.[2]

A more specific description of the interview subjects is as follows:

Of the defence lawyers, five of the seven were criminal lawyers in private practice. The

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1. It is notable, for instance, that in Ogloff's (1991) study of the insanity defence, and Lowman's (1989) study of prostitution enforcement, B.C. Provincial Court judges were approached, but in both cases declined to be interviewed (see also Bohmer, 1973). It is possible that judges are "gun-shy" of researchers as a result of studies such as Hogarth's (1971), which was seen as casting the judiciary -- more specifically, their decision-making practices -- in an unfavourable light.

2. Another group of persons not interviewed were the patients themselves. This group was not included because the present study was concerned primarily with administrative practices, and because of the practical and ethical problems involved in getting patients to consent to participate in a study; the "patients' perspective" would nonetheless be a worthy topic for a future study.

other two worked for non-profit organizations, with one having particular experience acting as a patient advocate at the Review Board, and the other having experience acting as a patient advocate at the provincial court. All seven were based in the Lower Mainland of B.C.

Of the Crown Counsel, four of the seven worked at a regional Crown office (i.e. B.C. Supreme Court), while three worked at the provincial court level; the regional Crown prosecutors had all previously worked in the provincial court. Three of the seven had special experience working as "mentals prosecutors" at the provincial court (more on this below). All seven were based in the Lower Mainland.

The fifteen Forensic Services staff were chosen to represent a cross-section of mental health disciplines. They are listed below, and are identified, depending on their work location, as "inpatient" (working at F.P.I.), "outpatient" (working at the Vancouver Forensic Outpatient Clinic), or both.

Senior Administrators: four, with two responsible for inpatient and outpatient services, and two responsible for inpatient services.

Psychiatrists: four, with all four working in both inpatient and outpatient settings.

Clinical Psychologists: two, with one working in inpatient, and one working in inpatient and outpatient settings.

Nurses: three, with all three working in the inpatient setting.

Social Workers: two, with both working in the inpatient setting.

The total number of subjects in this study (thirty) was somewhat arbitrarily chosen; however, it was felt that this number would generate a sufficient body, and diversity, of opinion, and also that it would be a manageable number for a single researcher.

It can be seen that the numbers are "weighted" in favour of the Forensic staff, since this group makes up one half of the sample. This was in part because it was harder to find legal personnel who were familiar with, and willing to talk about, Bill C-30; these individuals did not have the same volume of contact with cases involving mental disorder. This disparity in numbers is dealt with (in the Results) by presenting opinions from the different occupational groups separately.[3] In retrospect, however, it would have been useful to have had greater representation from the Review Board, with regard to forming a picture of the review process (see "Issue Number Eight" in Chapter Five).

ii) How the sample was chosen. The method of sampling potential interview subjects in this study can generally be described as "purposive" (Palys, 1992, p. 146); that is, persons were intentionally sought out because of a presumed familiarity with forensic psychiatry. This is obviously not a random procedure, and so the results cannot be said to be necessarily representative of a particular occupational (or more broadly defined) group. The difficulty with sampling, in the context of this particular study, is that defence lawyers and prosecutors in B.C. may vary widely with respect to their knowledge of the mental disorder provisions in the Criminal Code, with some having considerable interest and expertise, and many having none;[4] thus, interviews based on a random sample, or questionnaires based on a 100%

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3. It might also be noted at this point that while defence lawyers, prosecutors and psychiatrists differ occupationally, one cannot necessarily presume that they differ ideologically.

4. This view is based on the author's own personal experience, and was confirmed by a number of the interview subjects; see also Eaves, Roesch, Glackman & Vallance (1982). Familiarity with the mental disorder provisions in the Code is a function of several factors, such as personal interest, geographic location (with the Vancouver Provincial Court, for instance, seeing a relatively high volume of mental disorder cases), and length of time on the

sample, might turn up a large proportion with little familiarity with the subject. It was felt that a purposive sample would be a more efficient procedure, and a richer source of information. It was also felt that purposive sampling was congruent with the exploratory nature of this study.

While limited in terms of representativeness, it was hoped that the sample used in this study would turn up some useful, heuristic insights; further, an attempt was made to contextualize the subjects' comments by complementing the interviews with more quantitative information from the archival material from Forensic Services.

The Forensic Services staff were, as noted above, chosen to represent a cross-section of disciplines. Individuals were sought on the basis of seniority and prominent placement in the organization. In most instances, the identity of these individuals was known to the author in advance, because of previous work experience. A smaller number (initially unknown to the author) were suggested as potential subjects by co-workers. The administrators were all senior officials. The psychologists interviewed were the two most senior of the three working at F.P.I. Similarly, the social workers were the two most senior of the three working at F.P.I. The three nurses represented the two head nurses on the F.P.I. wards that deal with pre-disposition assessments, and the senior "nurse case coordinator", who was the hospital's representative at Review Board hearings. The four psychiatrists were all experienced forensic clinicians, and were the "busiest" of the nine who had worked at F.P.I. in 1990, in that they had been responsible for the largest proportion of assessments done.

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job. Concerning length of time on the job, it may often be the case that Crown prosecutors, particularly at the provincial court level, are relatively young and inexperienced (see Grosman, 1969).

Coming up with defence and Crown lawyers familiar with the "mental disorder" provisions was more difficult. In most cases the identity of such individuals was not known by the author in advance. It was thus necessary to ask persons already interviewed to recommend colleagues as potential interviewees.

With respect to the Crown Counsel, it was known by the author that the Vancouver Provincial Court had a special "mentals prosecutor", who handled all formally identified mental disorder cases (often when the question of fitness to stand trial was brought up). This jurisdiction is apparently the only one in the province with such a specialized position. For the study all persons (three) who had worked in this position during or after the transition to the Bill C-30 legislation were interviewed. Additionally, the Forensic Services staff interviewed were asked for the names of Crown prosecutors who had a special expertise in mental disorder cases; several names were suggested, and a number were suggested by more than one person: from this group four additional persons were chosen for the interview.

In the case of the defence lawyers, one person was known in advance by the author (the person working for the non-profit society who acted as an advocate for persons at the provincial court). The other six names were suggested by Forensic Services and Crown Counsel staff in interviews; several of the defence lawyers interviewed were suggested by more than one person.

Finally, the Review Board official was known in advance by the author, and was known to have considerable knowledge of forensic psychiatry. It should be noted that this person held an administrative position, and did not actually sit on the Board at the review hearings.

Of the persons originally approached for interviews, seven declined to be interviewed; these included one Forensic staff person, three defence lawyers and three Crown Counsel. In all cases the stated reason for declining was a lack of familiarity with the new legislation.

iii) Limitations of the sampling procedure. The sampling procedure used in this study has several limitations that should be kept in mind when reading the results. First, as noted earlier, the sample was not randomly chosen and so there is some question about the representativeness of the comments given by the different individuals and occupational groups.

Secondly, while choosing senior, experienced staff for the interviews has some obvious advantages -- such as knowledgeability and an historical perspective -- there is a potential disadvantage: persons used to doing things a certain way for a long period may find a change in the system more unsettling than would less experienced persons. This may be pertinent when one is attempting to assess the impact of new legislation.

Finally, it can be seen that it was necessary to choose several of the interview subjects by a "snowball" procedure (Palys, 1992, p. 148), that is, using the recommendation of one subject as the basis for choosing another. A potential problem with this method is that subjects may recommend like-minded individuals, so that, for example, in the mental health debate between medical paternalism and civil libertarianism, one may end up seeing only one side of the issue. In fact, that did not seem to happen in the present study, in that both sides of some rather contentious issues were expressed; this was because (in part) interview subjects were quite helpful in recommending other subjects on the basis of the other person's familiarity with the topic, regardless of ideological persuasion. As well, different

occupational groups were deliberately included in the sample, since it was assumed that defence lawyers and prosecutors, for example, might have different perspectives on some issues.

iv) The interview instrument. Subjects were asked a list of questions, in-person, about specific aspects of the implementation of Bill C-30; the list is reproduced in Appendix D. The questions were intended to provide information relevant to the ten issues listed earlier in this chapter. Fourteen questions were asked of all subjects, and an additional two were asked of the Crown and defence lawyers.

Some comment should be made on the way the interview questions were phrased. In brief, subjects were asked whether particular provisions would have an impact, rather than whether they had had an impact. This was necessitated by the fact the law had only recently been implemented, so that, in a number of instances, subjects had not had direct experience dealing with the new provisions. Where subjects did have direct experience with the new provisions, these responses were distinguished from answers that are more speculative.

The questions were open-ended: while they could be answered "yes or no", subjects were encouraged to expand on their comments and offer reasons for their opinions.

An in-person interview of this type was chosen for several reasons. First, the author's knowledge of certain aspects of the forensic psychiatric and court systems was somewhat limited. Second, the interviews covered a rather wide range of complex issues, of which some subjects had only partial knowledge. For these reasons, it was decided that a less structured format would offer more flexibility, the chance for discovery, and the opportunity to clarify and look in depth at more difficult issues. It is probably safe to say that a mail-out

questionnaire would not have been appropriate for an exploratory study of this type. On the other hand, a future questionnaire, building on the present study, and concerning more limited aspects of Bill C-30, would likely be a worthwhile project.

The interview was pre-tested (albeit to a limited extent) by talking with three Forensic staff persons to ascertain the appropriateness and relevance of the questions.

v) Limitations of the interview. One of the main problems with open-ended interviews concerns the coding and organizing of information (Palys, 1992). To deal with this matter the interview results were broken down by occupational category (Forensic staff, defence and prosecution) and an attempt was made in each instance to summarize any trends in responses, particularly where there was a consensus of opinion.

In trying to "make sense" of the interview results, several problems were encountered. For instance, in some cases there was no consensus of opinion (even within occupational groups). Another problem was that one question -- on the role of the Review Board -- while leading to a number of informative comments, was probably (in retrospect) too broadly framed. As well, there was the problem that on some issues a number of respondents had insufficient familiarity with the issue to offer an opinion; because of this, a distinction was made, in presenting the results, between comments about what was happening as a result of Bill C-30, and what would happen (in the opinion of the respondents).

vi Interview procedure. Interviews were conducted from September to December, 1992; in other words, the new legislation had been in effect for seven to ten months at the time of the interviews. Interviews were done in three "waves"; first, Forensic Services personnel, second, prosecutors, and third, defence lawyers. This ordering was done for two

reasons. First, it was assumed that the defence lawyers and prosecutors would have less contact with "mental disorder" cases than the Forensic staff, and so would need more time to become familiar with the new provisions. Second, Forensic staff were interviewed first so they could be asked to recommend names of legal personnel as potential interview subjects (see "how the sample was chosen" above).

Interview subjects were initially approached by phone with the interview request. As noted earlier, seven persons originally considered as potential candidates declined to be interviewed. Persons agreeing to be interviewed were visited at their place of work by the author, where the interviews took place. Interview subjects were given a consent form (see Appendix E). In most cases this was given to the interviewees, who kept a copy, at the time of the interview. Three persons requested that the consent form and a list of questions be sent to them in advance.

Interviews ranged in length from 45 to 90 minutes, with the average length being about an hour.

Interview responses were written down by the author; it was decided not to use a tape recorder to avoid defensiveness on the part of the subjects. An effort was made to record responses verbatim, although it is acknowledged that some gaps in information may have resulted.

Archival Information

In the present study, archival information from the B.C Forensic Psychiatric Services Commission was gathered to gain a more quantitative sense of the first year of the Criminal Code changes. Access to this information was granted following a request to the Executive

Director of the Commission (see Appendix G).

Archival data for the study came from three sources. First, information for some of the variables of interest came from print-outs from the computerized Forensic Services patient information system; the variables captured in this manner were: total number of assessments, by year, at F.P.I.; numbers committed to F.P.I. as NGRI or NCRMD, by year; and, numbers of NCRMDs/NGRIs given absolute discharges, by year.

Second, for the remaining variables (duration of assessment, number of NCRMD assessments, number of outpatient fitness assessments, number of NCRMD cases given immediate out-of-custody dispositions, number of assessments making reference to particular fitness standards, and number of assessments making reference to particular clinical and extra-clinical issues) information came from a manual analysis of clinical files. The manual analysis was necessitated in part because not all the data of interest were captured in the patient information system,[5] and in part because the Bill C-30 changes created categories (such as "outpatient fitness assessment") that had not existed before, which meant that new codes had to be set up for this information to be entered into the patient information system; at the time this study was being carried out the new codes had not yet been installed.

A third source of information came, late in the project, from a parallel study conducted, in-house, by B.C. Forensic Services staff; this information was used to fill in

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5. Some variables were "partly" captured by the patient information system, but required clarification by a manual file analysis. This was the case with the variable "length of assessment": length of patient stay is captured by the F.P.I. patient information system, but unfortunately, for patients who are certified and have charges stayed, length of assessment is not separated out from length of time spent as "certified with charges stayed." (This point is discussed in more detail in the next chapter.).

some of the gaps created by the limitations of the patient information system. Specifically, information (initially inaccessible to the author) was obtained on outpatient dispositions for out of town (Greater Vancouver) cases of persons found unfit or NCRMD.

The archival part of the study employed a 100% sample, i.e. for each variable looked at, all cases from both the "pre" and "post" period were included for analysis. "The first year" was defined as Feb. 4, 1992 to Feb. 3, 1993, inclusive. It was necessary to encompass all twelve months of the calendar to account for any possible seasonal effects.

The comparison period (preceding Bill C-30) varied depending on the variable being examined. As noted above, information on some variables was gained relatively easily through the patient information system; for these variables it was possible to gather information, in the "before" period, going back a number of years. For variables requiring a manual file analysis, however, only a one or two year comparison period was used. For the variables requiring a content analysis of psychiatrists' letters to the courts, given the time this process required, it was only possible to use a single year comparison period. In these cases the 1990 calendar year was used. It was felt that using 1990, rather than 1991 (the year immediately preceding Bill C-30), would hopefully avoid incorporating an "anticipatory effect" in the "before" period (i.e. changing practices in anticipation of a change in the law), and thus provide a clearer sense of the impact of Bill C-30. For the other variables, such as duration of assessment, and number of assessments, data from 1991 are included (as well as the 1990 data). It was decided to do this because, while these variables necessitated a manual file analysis, they were more easily extracted than the two (above) requiring a detailed content analysis of psychiatrists' letters. For these variables, then, a two year "before" period

is used. While the comparison period varies, depending on the variable being examined, it was felt that -- where possible, given time constraints -- it was better to include more data than less, to provide a better basis for comparison.

The cases used for analysis in this study were: (i) clinical files of those persons seen for inpatient assessment at the Forensic Psychiatric Institute (F.P.I.); (ii) clinical files of persons detained at F.P.I. as NCRMD; (iii) clinical files of those persons seen for new categories of outpatient assessment at the Forensic Services Vancouver Clinic (i.e. outpatient fitness and NCRMD assessment); (iv) clinical files of those persons found NGRI/NCRMD and initially admitted to F.P.I. or the Vancouver Outpatient Clinic.

The variables studied in the archival analysis are given below, separately, corresponding to the particular research issue being examined. As noted earlier in this chapter, Issues Numbers One, Six and Eight did not involve archival data (see "Issues addressed in the study" above). Because this study concerns a number of separate issues it was decided that, for clarity of presentation, a general description of how variables were operationalized would be given at this point, with a detailed description being included in the next chapter, alongside the corresponding results. It was felt that this would obviate the need for the reader to constantly flip back and forth between the two chapters.

Issue Number Two: Clarifying and narrowing the focus of pre-verdict assessments. In examining this issue, files of persons undergoing pre-verdict (pre-trial or at trial) assessment at F.P.I. in the first year of the new law were compared to those from the 1990 calendar year. Data concerning the issues requested by the courts for assessment were gathered from the referral forms on file. Data concerning the issues addressed by psychiatrists

in their assessments were gathered by a content analysis of psychiatrists' letters to the courts; issues included were: mental state, treatment needs, dangerousness, sentencing, and release restrictions.

Issue Number Three: Getting fitness assessments to conform to legal standards. In examining this issue, files of persons undergoing fitness assessment at F.P.I. in the first year of the new law were compared to those from the 1990 calendar year. A content analysis of psychiatrists' reports to the courts was performed, with report "completeness" measured by seeing whether reports made reference to the fitness standards now in the Criminal Code, i.e.: Can the accused communicate with counsel? Is the accused aware of possible consequences? Is the accused aware of the charge? And, does the accused know the roles of the court officials?

Issue Number Four: Shortening the duration of fitness assessments. In examining this issue, the mean and median duration of assessment for those persons seen at F.P.I. in the first year of the new law were compared to data from the preceding two years. Whether persons had assessment extensions or were "re-remanded" was also accounted for. Two secondary issues were also examined: (i) the effect of duration of stay on the composition of assessments was measured by counting the number of assessments with social work and/or psychological reports on file; (ii) the effect of duration of stay on rates of unfitness was measured by calculating the proportion of persons found unfit at the end of assessment.

Issue Number Five: Performing fitness assessments out-of-custody. In examining this issue, data were gathered on the number of persons seen in the first year of the new law at the Vancouver Outpatient Clinic for the "new category" of assessment (outpatient fitness and

NCRMD). Information on the nature of the offence was also accounted for (to provide a tentative comparison between inpatient and outpatient remandees).

Issue Number Seven: Increasing numbers of court-ordered assessments. In examining this issue, data were gathered on the number of persons seen for inpatient assessments at F.P.I., by month, in the first year of the new law; these figures were compared to those from the preceding two years.

Issue Number Nine: Less restrictive dispositions for persons found to be unfit or "not criminally responsible." In examining this issue, data were gathered on the increase in the number of absolute discharges of persons found NGRI/NCRMD in the first year of the new law, compared to the previous 15 years. As well, data was gathered from the first year of the new law on the number of persons found NCRMD and unfit and given immediate conditional discharges to the Vancouver Outpatient Clinic (a practice not followed previously).

Issue Number Ten: Greater utilization of the "not criminally responsible" defence. In examining this issue, data were gathered on the number of persons assessed for criminal responsibility at F.P.I. in the first year of the new law, compared to the previous two years. As well, data were gathered on the number of persons found NCRMD (and admitted to Forensic Services inpatient or outpatient facilities) in the first year of the new law, compared to the numbers found NGRI in the previous ten years. To get a sense of the patient profile, information on diagnosis and criminal charge was also gathered for these cases.

Finally, it should be noted that archival data from the B.C. Review Board was requested by the author for this project, to supplement data made available by the B.C.

Forensic Psychiatric Services Commission.[6] At the completion of the project, however, the Review Board data had not been made available, primarily because the Board had not had enough time (as of September, 1993) to prepare summary statistical information on the first year of the new law.[7]

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6. The new Criminal Code in fact states that "the Review Board may make any disposition information, or a copy of it, available on request to any person.....that has a valid interest in the information for research or statistical purposes" (s. 672.51(9)).

7. This reason was given to the author in phone communications with the Board chairman. It should be noted that the Chairman had agreed, in principle, with the legitimacy of the request for information, although (apparently) there was some concern about, and time spent in, establishing a protocol for future research requests.

Results

Issue Number One: Postponing Addressing the Question of Fitness at Court

The new Criminal Code provisions give greater discretion to court officials, than was the case prior to Bill C-30, with respect to postponing the question of fitness to stand trial (see Chapter Two). This is apparently a response to the criticism that it was too easy in the past for prosecutors to send an accused person off on a psychiatric remand -- depriving them of their liberty -- without necessarily having to first establish a viable case against the accused. The court now has the discretion to postpone the fitness issue: at preliminary hearing, until the prosecution has presented a prima facie case; at trial, right to the end of the trial (s. 672.25). Further, the new Code limits the prosecution's ability to request a fitness assessment for summary conviction offenses (s. 672.12); this limitation is not particularly stringent, however, since the prosecutor merely has to "satisfy the court that there are reasonable grounds to believe that the accused is unfit." Whether the courts will be likely to postpone dealing with the fitness issue is uncertain, however, since there is some indication -- albeit from anecdotal evidence -- that they have been reluctant to do so in the past (Eaves, Roesch, Glackman & Vallance, 1982; Lang, 1990; Mohr, 1978). This issue was addressed, in the present study, by interviews only, since the author did not have access to court documents.

Interview Results

Will the courts be more likely now to postpone addressing the issue of fitness?

Persons interviewed were asked: given the provisions now in the Code (described above), will the courts be more likely now to postpone addressing the issue of fitness? Only the prosecutors and defence lawyers were asked about this, since it was assumed Forensic

personnel would be, for the most part, unfamiliar with the subject.

Briefly, the majority opinion of those interviewed was that the courts would not use the new provisions to put off dealing with fitness, that it would be dealt with, as per tradition, "right away." One qualifying note should be added: these opinions were based on an extrapolation of past experience, since none of those interviewed had actually seen the new provisions for postponing fitness in use.

Of the seven prosecutors interviewed, three stated that they were "uncertain" as to whether the new provisions would have any impact in this area; the other four all stated that the provisions would not be used, that is, the courts would not put off dealing with the fitness issue. One commented that the whole idea (postponing dealing with fitness) was "ridiculous" and that "this would never happen." Another stated that "defence counsel don't want unfit clients; they're hard to defend." A third suggested that "you have to resolve the fitness issue first, otherwise it could be considered a violation of the Charter of Rights." (This last comment refers to the issue of being tried "in absentia.") Two of the prosecutors stated that "in theory" postponing the issue was a good idea, in that it offered the defence an opportunity to expose a weak prosecution case, but that in practice it would be unlikely to happen. One person noted that defence counsel were not usually consulted when psychiatric assessments were being considered after the accused's first appearance in court. Finally, one prosecutor suggested that persons being considered for fitness assessment were usually so sick that there was a ready consensus that the individual should not proceed any further through the court proceedings.

Of the seven defence lawyers interviewed, one was "uncertain" as to whether the new

provisions would have any impact in this area. Of the other six, five stated that it was "unlikely" that the courts would use the provisions to postpone dealing with fitness. Of the five stating it was unlikely, three quite clearly were of the view that the fitness issue should not be postponed, that it should be dealt with right away. Echoing the comments of the prosecutors, one of these three stated:

> How can you represent someone who's unfit? It's like trying them "in absentia." It's unfair to the accused. Defence lawyers don't want unfit clients.

These comments would seem to indicate that the new provisions will likely have little impact when defence lawyers do not see postponement as being in their clients' best interests.

Two of the five defence lawyers stating it was unlikely commented that, in theory, postponing the issue was a good idea in some instances, since "the Crown should have a case", but both added that in practice it was unlikely to happen. One of the two suggested that even where a defence lawyer might argue for postponing the issue, he or she might be overruled by the judge.

Only one of the defence lawyers suggested that it was possible that the new provisions would have an impact in this area, but added that postponing the fitness issue would only be likely to happen "in shorter, less serious matters, where resolving the trial on the merits could be done quickly." This person added that this scenario was made less likely by the fact that judges "are less likely to order psychiatric remands for minor matters, such as a 'dine and dash,' and so in these instances the accused is usually treated as if he's fit, even if he's not."[1]

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1. In fact, data from the present study indicated that fitness assessments were sometimes ordered for minor offences, notwithstanding the perceptions of this defence lawyer.

Issue Number Two: Clarifying and Narrowing the Focus of Pre-Verdict Assessments

As noted in Chapter Three, a criticism of the old Criminal Code was that the purpose of pre-verdict (pre-trial or at-trial) psychiatric assessments was not clearly stated (Addington & Holley, 1987). Section 537(1) noted that a "period of observation" could be ordered (at preliminary hearing) "where....there is reason to believe that the accused may be mentally ill." While pre-trial assessments may commonly be ordered to evaluate fitness to stand trial, it has been suggested that psychiatrists may, in the absence of any explicit directive, be expansive in their investigations, and comment on other issues such as criminal responsibility, dangerousness, treatment, and dispositional and sentencing recommendations (Lindsay, 1977; Menzies, 1989; Ogloff, 1992; Webster, Menzies & Jackson, 1982). An expansive assessment may indeed be useful to the courts, who may be at a loss as to how to handle cases involving mental disorder (Ogloff, 1991). On the other hand it has been argued that expansive assessments are potentially harmful and prejudicial to the accused's case, and that if a remand is ordered as a "fitness assessment", it should just concern itself with fitness (Law Reform Commission, 1975; Menzies, 1989).

The new Criminal Code spells out more clearly the purpose of pre-trial assessment (notably: evaluation of fitness and/or mental state at the time of the offence). Further, the Code provides a standardized referral form where the referring person ticks off the service(s) to be provided (see Appendix B). In B.C., where the Forensic Services Commission already had referral forms for the courts, the agency's forms have been modified to be consistent with the type of form now given in the Criminal Code (see Appendix C); this means that in B.C. referring persons can presumably no longer use the referral form to request an opinion

on certifiability, treatment needs, personality assessment, social assessment, or "other recommendations" (these being categories on the old Forensic Services forms: see Appendix A).

I) Interview Results

Will the new referral forms narrow the focus of pre-trial assessments?

Persons interviewed for this study were asked: with the purpose of assessments apparently clarified and narrowed -- as reflected in the new referral forms -- will this mean that psychiatric reports to the courts will be less expansive?

In brief, most of those responding suggested that there would not be much change in the expansiveness of pre-trial psychiatric reports after Bill C-30. A number of those suggesting reports would be less expansive stated that this would not necessarily be due to the change in referral forms, but rather to other factors such as (i) the shorter time available to do the assessment and (ii) a general reading of the intent of the new legislation. Overall, it was notable that the importance of the referral forms per se was downplayed.

Of the fifteen Forensic staff interviewed, the majority stated that the new forms would make no difference with respect to what was addressed in assessments, and that psychiatrists who were expansive before would likely continue to be expansive, while those who were concise would continue to be concise. Eight stated "no difference" while four stated they were uncertain; on the other hand three stated that it was "possible" or "probable" that the forms would make a difference. Only one of the four psychiatrists interviewed suggested that the forms would have any impact.

Those stating "no difference" made a number of supporting comments. For instance,

two people -- a nurse and a social worker -- said that they didn't usually see the referral form, anyway.[2] Further, a nurse commented that "quite often the forms are filled out wrong, so it's hard to say what they (the court) want." And a psychiatrist, interviewed eight months after the new forms came in, stated that "we're still getting the old forms quite frequently." Finally, a psychologist suggested:

> I think the Crown will still want as much information as they can get from the assessments, notwithstanding the "intent" of the new referral forms. To do this they can just add additional comments and requests onto the existing forms.

(Empirical data, offering some confirmation of the psychologist's assertion, is given following the interview results.) Interestingly, of the group stating "no difference", two Forensic staff persons said they didn't follow the referral forms, anyway. One suggested that "we will do what is necessary and relevant; we don't necessarily follow the forms." A second stated:

> I don't usually look at the referral forms. I don't want the law to dictate the nature of my assessment. If the request is to assess fitness, well, you can't just look at fitness out of context. You have to look at other issues such as mental disorder, psychiatric history, treatment issues, the social context. Unless I am told specifically <u>not</u> to address something, I will do as comprehensive an assessment as possible.

The three that suggested the forms <u>would</u> make a difference had a different perspective. All stated that they <u>did</u> follow the specific requests on the referrals. One of this group suggested that if fitness assessment was the request, that is all that would be looked

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2. It seems fairly certain that the attending psychiatrists, who were the ones who wrote the letters to the courts, <u>were</u> given the court referral forms. The fact that other staff such as social workers did not always see the referral forms is still significant, since the psychiatrists would sometimes use the social work assessments to help create the court letters.

at. A second person suggested:

> Before, in the pre-trial assessment, the question was: "What are we going to do with this guy?" Now, we'll be focusing mainly on the fitness question.

In the same group a psychiatrist commented that "we'll just be looking at the person's current status, we won't be doing any histories."

Concerning the expansiveness of assessments, an important issue that had nothing to do with the referral forms came up several times in the responses by Forensic staff to this question. Four persons suggested that if assessment reports were less expansive after Bill C-30, this would be primarily due to time restrictions, i.e. the fact that assessment periods were now shorter (because of the new legislation). All four stated that fewer issues could be addressed and reported on when the patient was only in for a five-day assessment. Two of the four were from the group that said the new referral forms would affect the expansiveness of assessments, but added that time was a more important factor than the nature of the forms. The impact of the new, shorter remands is addressed in more detail in a later section in this chapter (see "Hypothesis Number Four").

Of the seven prosecutors interviewed, two were uncertain as to whether pre-trial assessments would be less expansive after Bill C-30, or more specifically whether the new referral forms would dictate a narrower sort of assessment.

Of the five prosecutors who ventured an opinion, four suggested that it was "possible" or "probable" that pre-trial reports would be less expansive after Bill C-30, while one stated there would be "no difference." Of the four that suggested there would be a difference, two qualified their comments by stating that the narrowing of assessments would not be due to the referral forms per se, but rather to a general reading of the intent of the new legislation.

One of these two, in playing down the significance of the forms, made a rather telling comment:

> Before, Forensic Services used this referral form where there was a whole bunch of "tick boxes" that you could check off.[3] We used to just tick them all in an indiscriminate fashion. Frankly, we didn't worry too much about it. So, I don't think you can read too much into the purpose of the assessment by looking at those old forms.

Two of the prosecutors noted that one could "get around" the new referral forms, anyway, by either combining an old, "expansive" referral form with one of the new forms, or by simply adding on requests to the new forms (see "Archival Data" later in this chapter). One prosecutor commented:

> It is true that the purpose of pre-trial assessments has been narrowed somewhat with Bill C-30, but you have to understand that there is still room for discretion in this matter. We are often still interested in getting some ideas from the psychiatrists on treatment and disposition, for example. We just have to justify it more.

(It should be noted that the Forensic Services referral form -- see Appendix A -- was usually completed by the prosecutor in the case -- not a judge.)

The interviews in this area sometimes led to a discussion of whether or not expansive assessments are a "good" or "bad" thing. Four prosecutors commented on this issue, and all four disagreed with the argument that pre-trial assessments are used "strategically", as a way of gathering information to be used against the accused. One stated:

> The relationship between defence counsel and the Crown in this court is non-adversarial. I try to balance the best interests of both the public and the accused.

Another commented:

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3. See Appendix A.

> You have to understand that most defence counsel don't care about the "expansiveness" of assessments. If there is a concern in this area, they always have the option of telling their clients not to tell anybody anything while at F.P.I.

Finally, two prosecutors suggested that the focus of pre-trial assessments may shift more to examining mental state at the time of the offence, in anticipation of an increasing use of the defence of Not Criminally Responsible on account of Mental Disorder; this issue is discussed in more detail in a later section of this chapter (see "Hypothesis Number Ten").

The seven defence counsel interviewed were somewhat less familiar with the referral forms referred to in this question than were the Crown and Forensic personnel. The two that had some familiarity with the forms both stated that the change in referral forms per se would "not make much difference" with respect to what was addressed in pre-trial assessments. The other lawyers spoke in more general terms about whether assessment reports would be less expansive now because of the apparent intent of the new legislation. Four of the seven were "unsure" as to whether there would be any change in the nature of assessment reports. The other three stated that there would likely be "no difference" in the nature of the reports; two of the three added that reports should be less expansive now, but probably would not be. One of the two making this statement said the statement was based on viewing reports written after Bill C-30. The other person making this statement commented that "the Crown will still be using psychiatric assessments to get information through the back door."

Three of the defence counsel offered some comments on whether expansive assessments were a "good" or "bad" thing. Interestingly, two of the three were relatively unconcerned about the expansiveness of psychiatric assessments. One stated:

> In my opinion the Crown doesn't abuse the psychiatric remand process, or use it to, say, help build a case against the accused. I would say there is a good working relationship between the Crown and the defence bar in B.C.

Similarly, the other lawyer commented:

> I trust the Crown. I've never seen them use the psychiatric remand as a way of gathering information to be used against the accused. They wouldn't bother doing it with the sort of cases I deal with, which are mostly pretty minor. The assessment process is often used to get the person some treatment; then they (the Crown) can often be persuaded to stay the charge, either out at F.P.I., or when they return to court. I don't see this (undergoing psychiatric assessment and then having charges stayed) as being against my clients' interests.

This last lawyer added that while he had some concerns about psychiatrists commenting on "dangerousness" in their reports, "I can understand the concern of the Crown with respect to this issue."

The third lawyer commenting on expansive assessments had a quite different perspective; this person was suspicious that psychiatric remands were being used as a way of gathering information that could be used against the accused. This individual admitted to an adversarial stance vis-a-vis the Crown, and suggested that Forensic Services were on the side of the Crown, and were not a neutral party.

It may be noted also that one of the defence lawyers brought up the issue, also raised in the interviews with the Crown, that assessments would now turn more to looking at mental state at the time of the offence, in anticipation of the defence of NCRMD being raised more frequently.

Finally, the Review Board official interviewed stated that pre-trial assessments should be less expansive after Bill C-30, but was unsure as to whether they would be.

As a concluding comment, it was interesting -- and perhaps disturbing -- to note that

several clinical and prosecutorial staff felt free to, in effect, circumvent the intent of the new assessment procedures by ignoring, or adding onto, prescribed assessment directives.

II Archival Data

In this section an attempt is made, by way of a content analysis of clinical files, to determine whether the use of the new referral forms has clarified the purpose of pre-verdict assessments. The premise here is that reports to the court at the pre-verdict (pre-trial or at trial) stage that are unnecessarily "expansive" may be (as noted earlier) prejudicial to the accused's case. In doing this it is necessary to look both at what is requested by the courts for assessment (i.e. how the new forms are used) and, correspondingly, what issues are addressed by psychiatrists in their reports.

Before discussing the results of the content analysis, it is necessary to address some of the limitations of the method used. First of all, it is probably an obvious or trivial finding that the use of the new forms will clarify or narrow what is being requested for assessment. This is because, in jurisdictions that previously did not use referral forms, there now is a referral form; and, in B.C., existing forms have (apparently) been replaced with new forms that offer the referring person fewer issues to request for assessment (see Appendices A and B). Thus, on the face of it, using the new forms will, by definition, clarify the purpose of assessment.

This conclusion, however, is complicated by the suggestion that the forms cannot always be taken at face value. As noted in the interviews, at least one Crown Counsel suggested that items on the referral forms (Appendix A) had been (in the past) checked off in an indiscriminate fashion; further, several Forensic Services staff suggested that particular

psychiatrists would continue to be more (or less) expansive, regardless of the new forms, since their assessments were more a function of their personal style than the dictates of a form. Thus, there may be some question as to whether the "independent variable" in this case (the form) is having an effect.

A related problem is that any change in reporting style after Bill C-30 is difficult to interpret. For instance, if pre-verdict assessments do become less expansive after Bill C-30, this could be due to factors other than the new referral form per se, factors such as turnover in personnel (and thus changes in reporting styles), less time to do assessments (see Issue Number Four), or, as noted in the interviews, a general reading of the intent of the new legislation.[4]

Notwithstanding these problems, it was felt that a descriptive look at the question of "expansiveness" would be informative.

i) Use of the new forms. To begin with, it was found that the new referral forms (Appendix B) were being used in the first year of the new law. Two hundred and thirty-one of 250 pre-verdict assessments (92.4%) performed at F.P.I. contained the new referral form. Eight files were found to contain no referral form, while 11 had just the old form.[5] Based on a face value reading of the forms, this would suggest that pre-verdict assessments would become less expansive in the first year of the new law because the new forms have fewer

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4. Although this last factor would still represent an effect of the new legislation.

5. Exactly when the new referral forms became available, in each court jurisdiction, was not known to the author. The presumption made here was that form availability coincided with the proclamation of the new legislation, although it is possible that, in some cases, there was a lag in the provision of the forms.

issues to request for assessment.[6]

However, it was also found (in the first year of the new law) that in 96 cases (38.4%) files had both an old form and a new form. While it is not clear why this was the case, it is notable that in 74 cases (30%) where there was an old and new referral form on file, the issues requested for assessment on the old form were different than the issues requested on the new form (e.g. the new form would request "fitness" while the old form would request "treatment needs"). While this finding is difficult to interpret, it is consistent with the comments made in the interviews (see above) that in some instances the referring source may try to "get around" the restrictions of the new form by adding in issues with the old form.

It is also notable that in 22 cases (nine percent) additional requests were written onto one or another of the referral forms (in most cases by the prosecutor). The issues that were requested were various; they included "dangerousness," "treatment options," "possible diversion to the mental health system," "is he suicidal?," "recommendations on sentencing," "existence of mental illness," "general assessment," "recommendations for disposition," and "he won't obey court orders and is totally unmanageable in the community. Help!". In short, there is an indication that referring persons may want a more expansive assessment at the pre-trial stage, and are using the pre-verdict assessment to address issues other than fitness or criminal responsibility.

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6. This is also based on the finding that, if given the opportunity to request other issues, the referring source will take advantage of it. For instance, of the 247 pre-verdict assessments performed in 1990 at F.P.I. it was found that in 53% of cases four or more of the seven possible "check boxes" on the referring form (see Appendix A) had been ticked off; it was found that 60% of referrals had "existence of mental illness, including certifiability" checked, and that 48% had "treatment needs" checked.

There was also some confusion (or carelessness) evident, in that, in several cases, requests were made to assess categories that were not yet in effect, e.g.: "whether the accused is a dangerous mentally disordered accused" (see Appendix B).

Issues requested for pre-verdict assessment at F.P.I., comparing the first year of the new law with 1990, are shown in Table 1. The "issues requested" were all dictated by choices available on either the old or new referral forms, with the exception of "dangerousness", which was hand-written onto the forms by referring persons; other "hand-written" issues were not included because they occurred so infrequently.[7] For the first year of the new law, where some files could have both referral forms, a referral issue was counted if it appeared on either of the two forms.

Several points may be noted from Table 1. First, fewer assessments lacked a referral form in the first year of the new law. This would seem to indicate that, although the courts had a referral form available before Bill C-30 (the Forensic Services form), its availability was apparently not equivalent to that of the new Criminal Code form; if this is the case, the new situation may be an improvement.

Second, because the old Forensic Services form was still being used in the first year of the new law, requests for assessment of "mental illness, treatment, personality and social" were still given, as can be seen (these options are not available on the new Criminal Code form). However, it can also be seen that with the (apparently) diminishing use of the old forms there are relatively fewer requests for these four issues; by extension, and using a

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7. The (new) assessment issue of "assessment to determine disposition of persons found unfit/NCRMD" (which was requested very infrequently) is discussed later in this chapter (see Hypothesis Number Seven).

"face value" interpretation of the referral information, this would imply that assessments should be correspondingly less expansive.

Table 1. Issues Requested for Pre-Verdict Assessment by Year

	Year	
Issues Requested	1990 (n=247)	Feb. 92 - Feb. 93 (n=250)
No form on file	42 (17%)	8 (3.2%)
Fitness	184 (74.5%)	211 (84.4%)
NGRI/NCRMD	116 (47%)	124 (40.6%)
Existence of mental illness	170 (68.8%)	71 (28.4%)
Treatment needs	119 (48.2%)	59 (23.6%)
Personality assessment	64 (25.9%)	27 (10.8%)
Social Assessment	53 (21.5%)	27 (10.8%)
Dangerousness	8 (3.2%)	4 (1.6%)

ii) Issues addressed in assessment. To examine the "expansiveness" of pre-verdict assessments, a content analysis was performed on psychiatrists' letters to the court following pre-verdict assessment at F.P.I., comparing 1990 assessments (n = 247) to those done in the first year of the new law, Feb. 4, 1992 - Feb. 3, 1993 (n = 250). As noted above, one would (with reservations) expect the 1992-93 reports to be less expansive, since the list of possible issues for assessment has been narrowed (because of the new referral form), and, since in

54% of cases the new referral form was the only referral form on file (thus offering "fitness" and "NCRMD" as essentially the only choices for assessment). Again, this assertion is based on a "face value" reading of the referral forms.

All pre-verdict assessments were included in this analysis, except (a) cases where the assessment was not completed (e.g. the patient refused) and (b) cases where the person coming in for assessment was certified and had charges stayed, i.e. was "diverted"; in the majority of cases where the person was diverted no report to the court was completed. In 1990 36 of the 247 cases were diverted (14.6%), and two assessments were not completed; in the first year of Bill C-30 30 of the 250 cases were diverted (12.0%) and six assessments were not completed.

For the purposes of this study, six issues were accounted for in the content analysis of psychiatric reports. The first two are clinical issues: current mental state, and treatment recommendations. The other four issues are what might be termed "extra-clinical", in that they concern matters that, arguably, are not strictly within the mandate of a pre-verdict psychiatric assessment; these are: recidivism, sentencing recommendations, release restrictions and treatment as a condition of probation. It is conceded that determining what "should" and "shouldn't" be in a pre-verdict report is a complicated and controversial matter (see discussion earlier in this section, and Chapter Three); the purpose of this exercise, to remind the reader, is to get at least a partial sense of whether the apparent intent of the new law (to clarify and narrow the purpose of assessment) was being realized.

The issues were coded as follows:

i) Current mental state: any reference in the psychiatrist's letter to the court to an

examination of the accused's mental status or underlying mental disorder.

ii) Treatment recommendations: any reference in the letter to a recommendation about (post-assessment) treatment for the accused. "Treatment" was defined broadly, i.e. any sort of therapeutic intervention; this could be, for instance, psychiatric treatment, psychological counselling or substance-abuse counselling.

iii) Recidivism: any reference in the letter to an opinion about the accused's risk of reoffending; e.g.: "the accused is a serious risk for reoffending without psychiatric treatment."

iv) Sentencing: comments on the letter would be coded under this category in two ways. First, if there was a statement that the accused should be dealt with by the criminal justice system, rather than the mental health system; an example would be "this person should be held accountable for his actions, and is more appropriately a client of the criminal justice system." Second, if there was any recommendation about the type and/or length of punishment the person should receive; an example would be "incarceration may be a deterrent in this case", or, "the accused should receive a lengthy term of probation with the condition that he receive psychiatric treatment."

The reader is cautioned at this point about misinterpreting this category, since there may be the implication that psychiatrists were excessively punitive in their recommendations. In fact, psychiatrists rarely spoke about incarceration; more commonly, however, some would recommend periods of probation with conditions, as (apparently) a way of ensuring that the accused would receive treatment and "stay out of trouble."

v) Treatment as condition of probation: comments on the letter would be coded under

this category if there was a recommendation that maintaining psychiatric treatment in the community should be made a condition of probation. The difference between this category and the one above is that in this category the psychiatrist would not state an opinion about whether or not the accused should receive probation, but that if they did then psychiatric treatment should be made a condition.[8]

vi) Release restrictions: comments on the letter would be coded under this category if they referred to bail and/or probation restrictions, e.g.: "the accused should not be allowed to drink alcohol", or "the accused should not be allowed to return to his parents' home."

The overall results of the content analysis are shown in Table 2. As can be seen from the table, in both of the years studied, mental status and treatment recommendations were addressed in the vast majority of pre-verdict reports completed, which is hardly a surprising result given that these were clinical examinations. It is interesting to note, however, that treatment recommendations were (still) commonly offered in most cases (80 percent) in the first year of the new law, even though they were formally requested in only about one quarter of the referrals (see Table 1); this finding is consistent with the view (expressed in the interviews) that issues addressed in assessment are not necessarily dictated by referring information.

One can also note that, in a number of instances, assessment reports addressed the earlier-described "extra-clinical" issues (recidivism, sentencing, conditions of probation and release restrictions), without any formal (written) request to do so (except, as noted in Table

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8. As will be detailed shortly, one complication in this particular analysis concerns the fact that a recent B.C. Court of Appeal decision (Rogers, 1990) may have had an impact on the practice of ordering treatment as a condition of probation.

1, a few requests for "dangerousness"). It can be said, therefore, particularly with the 1990 assessments, that reports were "expansive" in a number of cases. What is interesting, however, is the apparent shift to less expansive reports in the first year of the new law, based on the smaller proportion of cases that included extra-clinical issues (Table 2). The question is why this should be happening: while there was (initially) a presumption that the new referral forms would "narrow" the assessments, the suggestion from the interviews was that any change in recording styles would not be easily attributable to the referral forms alone (if at all). The limited effect of the referral forms is also self-evident in that, as Table 2 shows, issues are addressed without a formal request to do so.

Table 2. Content Analysis of Pre-Verdict Psychiatric Reports

Time period	No. of cases referring to particular assessment issues					
	Mental status	Treatment recommend'ns	Recid-ivism	Sentencing recommend'ns	Treatment in probation	Release restrictions
1990 (n=209)	207 (99.0%)	178 (85.2%)	48 (23.0%)	49 (23.5%)	55 (26.3%)	54 (25.8%)
1992-93 (n=214)	213 (99.5%)	171 (79.9%)	36 (16.8%)	9 (4.2%)	26 (12.1%)	18 (18.4%)

Given the limitations of the method, it is difficult to say why reports were less expansive in the first year of the new law. One variable that can be accounted for, however, is the personnel factor. This has to do with the fact that different psychiatrists have different

reporting styles and, consequently, a change in the content of F.P.I. reports may be the result of personnel turnover. And, in fact, it was found to be the case that there had been a considerable turnover in psychiatric personnel at F.P.I between 1990 and 1992. To account for this, the data are reanalyzed in Table 3. In this table, only the reports written by the four psychiatrists present in both time periods (1990 and the first year of Bill C-30) are compared. To protect confidentiality, individual numerical totals are excluded, although individual percentages and overall numerical totals are included.

One can note, from Table 3, the individual variability in psychiatric report writing. For instance, in looking at the 1990 figures, one can see that "Dr. B" would very infrequently comment on "recidivism", but would commonly talk about release restriction while, conversely, "Dr. C" would frequently comment on recidivism and rarely talk about release restrictions.

Interestingly, even when holding "personnel" constant, one can still detect from Table 3 a decrease in report "expansiveness" in the first year of the new law (lower proportion of cases addressing "extra-clinical" issues). As noted earlier, it is difficult to say why this change came about. It is tempting to conclude that the change was a result of the new legislation, that is, new referral forms and, perhaps, a "general reading" of the intent of the new law. There may, however, be other contributing factors. For one thing, it is possible that reports are less expansive because assessment periods are now shorter (see Hypothesis Number Four) and there is thus less time to gather background and testing information on the accused. As well, psychiatric recommendations may have been curtailed as a result of an important B.C. Court of Appeal decision in Regina v. Rogers (1990). The Rogers case was

Table 3. Content Analysis of Pre-Verdict Psychiatric Reports, by Psychiatrist.

Number of cases referring to particular assessment issues

	Mental status		Treatment recommendations		Recidivism		Sentencing recommendations		Treatment in probation		Release restrictions	
	1990	1992	1990	1992	1990	1992	1990	1992	1990	1992	1990	1992
Dr. A	100.0%	100.0%	80.0%	82.3%	22.5%	29.4%	15.0%	0.0%	20.0%	14.7%	7.5%	0.0%
Dr. B	100.0%	100.0%	92.4%	92.5%	3.8%	5.0%	45.3%	10.0%	58.5%	15.0%	52.8%	22.5%
Dr. C	100.0%	100.0%	93.9%	100.0%	44.9%	33.3%	16.3%	0.0%	8.2%	0.0%	14.3%	0.0%
Dr. D	100.0%	100.0%	100.0%	81.8%	3.3%	0.0%	3.3%	0.0%	20.0%	9.1%	6.7%	13.6%
Totals	100.0%	100.0%	91.9%	87.3%	19.8%	13.7%	22.7%	3.9%	26.2%	12.7%	25.6%	11.8%
	(172)	(102)	(158)	(89)	(34)	(14)	(39)	(4)	(45)	(12)	(44)	(13)

Numerical totals: 172 for 1990, 102 for 1992

a Charter challenge to the practice of imposing psychiatric treatment on mentally disordered persons as a condition of probation; the court found this practice to be "an unreasonable restraint upon the liberty and security of the accused person" (as per s. 7 of the Charter). In fact, in several instances, Forensic Services psychiatrists would make (indirect) references to Rogers in their reports to the courts; for instance in one 1992 pre-verdict assessment the psychiatrist stated in the report: "Due to recent legislation, persons with mental illness cannot be forced to take treatment (that is, medications) under a court order", adding: "This is a situation where the law and clinical reality clash."[9]

9. The Rogers decision may, ironically, result in more restrictions being placed on the accused person's freedom: noting that probation conditions "should be designed to ensure the protection of the public" Justice Anderson, in the Rogers case, stated that the accused would still be responsible for maintaining his mental health and, if refusing to take medication, would be required to report to the probation office on a daily basis for monitoring. (There is a parallel here with the reasoning used in the Orlowski decision [Chapter Three] with the consideration of "future threat" due to medication non-compliance.) In one 1992 pre-verdict assessment the psychiatrist echoed the conditions given to Rogers, writing that, if the accused did not agree to treatment, the alternative would be to report to the probation office "twice a day, every day of the week." As well, it is possible that judges will now be more reluctant to order probation in such cases, opting instead for periods of incarceration.

Issue Number Three: Getting Fitness Assessments to Conform to Legal Standards

The old Criminal Code did not contain any standards by which fitness to stand trial could be assessed. It has been suggested that the absence of such standards may in part account for inconsistencies and idiosyncrasies in fitness assessments (Bagby, 1992; Roesch, Jackson, Sollner, Eaves, Glackman & Webster, 1984; Rogers, Gillis, McMain & Dickens, 1988). The implication is that inclusion of fitness criteria in the Code would aid the fitness assessment process, and produce more consistent assessments. The new Criminal Code in fact includes three criteria for establishing fitness, namely that a person may be unfit if unable to (a) understand the nature or object of the proceedings, (b) understand the possible consequences of the proceedings, or (c) communicate with counsel.

I) Interview Results

Will having standards included in the Criminal Code make fitness assessments more consistent?

Persons interviewed for this study were asked: "With fitness standards now in the Code, would fitness assessments conducted by psychiatrists be more consistent?"

In brief, a clear majority of the persons interviewed suggested that having fitness standards in the Code would make no difference with respect to how fitness assessments would be performed. A number of persons stated that the Forensic psychiatrists already knew the standards, but that this still did not prevent their fitness assessments from being inadequate or idiosyncratic.

The majority of the fifteen Forensic staff interviewed stated that having standards in the Code would make no difference in the way fitness assessments were conducted by B.C.

Forensic Services psychiatrists. Eleven persons stated it would make no difference while four stated that they were not sure whether or not it would make a difference; none, in other words, stated that the inclusion of standards in the Code would aid the fitness assessment process.

The eleven stating "no difference" all suggested that the Forensic psychiatrists were already aware of the standards now in the Code. Notably, all four of the psychiatrists interviewed stated that they were aware of the fitness standards and were already using them. One psychiatrist added that "those criteria (the three now listed in the Code) aren't the only ones anyway; there are others (from case law) that we may apply."

Whether awareness of the standards would mean more consistent reports was another matter, however; as one Forensic staff person pointed out: "Just because the doctors know the fitness standards, it still doesn't mean there won't be inconsistencies and biases in their reports." Another staff person commented:

> The doctors know the criteria now in the Code, but some of the doctors don't think much of them. Their attitude is: "I'll determine what fitness is." They may feel that the standards as given in the Code are inadequate, too narrow.

A psychiatrist indicated the tension between clinical and more structured approaches to assessing fitness:[10]

> We are aware of the fitness criteria (in the Code). It is true, however, that we get complaints from the Crown that our reports aren't standardized enough, don't address the right issues. The thing is, each case is different, you can't use a standardized approach. Each person may have his fitness impaired in a

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10. As noted in Chapter Three, a number of more structured instruments have been developed to help assess fitness. In the present study it was found that only one of the four psychiatrists interviewed used a structured fitness instrument with any sort of regularity (the Competency Screening Test; see Lipsitt, Lelos & McGarry, 1971).

> different way. I sometimes use a standardized fitness instrument, but clinical judgement still has to be paramount.[11]

One administrator commented on an additional problem:

> I think the doctors basically know the criteria, but they may not always express them adequately in written form. Sometimes they may have to phone in information (to the Crown) to clarify matters. I know one of the Crown (now no longer there) was always asking us for greater standardization in the fitness reports.

Finally, a psychiatrist stated:

> The problem is not just whether the psychiatrist knows the fitness criteria; often, the judge doesn't seem to know them. Different judges can have much broader, or narrower, conceptualizations of fitness. I've been in court when the accused is so psychotic he doesn't even know where he is, let alone what the "role of the prosecutor" is, and yet the judge will declare him fit.

The prosecutors interviewed offered comments similar to those of the Forensic staff. Of the seven prosecutors, one was unsure as to whether having standards in the Code would make any difference in the way fitness assessment reports were written; of the other six, none thought having standards in the Code would make any difference. Of these six, all felt that the Forensic psychiatrists were already aware of the criteria. Three of the six commented that, in general, the legal criteria were adequately reflected in the doctors' letters to the court. One of these three added that:

> Fitness is not a clear cut matter. It involves a subjective decision. You can't just go by the legal criteria alone, you need a clinical investigation.

The other three commented that although the psychiatrists might know the criteria, their

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11. In one of the letters to the court, following a fitness assessment, a psychiatrist wrote: "The concept of fitness is not a rigid one. Connecting psychiatric findings to legal criteria is not easy."

reports could still be inadequate and inconsistent. One of the three stated that "some reports seem to focus too much on mental state, and not fitness." Another commented:

> Having criteria in the Code won't make much difference. The psychiatrists knew the criteria before; the problem was they didn't apply them. They seem to be applying their own criteria. The reports can be very idiosyncratic, which is too bad because the legal questions are quite easy, actually. I'd like to see more standardization, the use of a form.

The defence lawyers interviewed were somewhat less familiar with this subject. Of the seven, three were unsure as to whether having fitness criteria in the Code would help the psychiatrists in their report writing. The other four stated that the Forensic psychiatrists probably were aware of the criteria anyway; three of the four said knowledge of the criteria would still not prevent reports from being biased or idiosyncratic. For instance one stated:

> It will still depend on the individual doctor doing the assessment. Some have broader standards of fitness, some have narrower.

A second suggested that the criteria in the Code were insufficient:

> Having those three criteria in the Code will make no difference. They used those criteria before. Those three aren't sufficient, anyway, to assess fitness. I have found that the Forensic psychiatrists lean too much toward finding the accused fit, when in my view the person may not be fit. A client like that is no good to me.

Finally, the Review Board official interviewed did not comment on this question.

As an addendum the reader is reminded that the question used in this interview concerned the perceived effect of a new statute on B.C. Forensic Services Psychiatrists, not psychiatrists or physicians in general. Thus, while forensic specialists may be aware of the criteria used to determine fitness, this may not be true of non-specialists, who may benefit from having (at least some) criteria in the Code to refer to.

II) Archival Data

To examine the adequacy of pre-verdict fitness assessments, and the possible impact of the new Code, a content analysis of psychiatric reports, comparing pre and post Bill C-30 data, was performed. The approach used borrows from a scheme suggested by Bagby (1992) in his analysis of fitness reports at the Metropolitan Toronto Forensic Service.

Briefly, psychiatrists' reports to the courts were examined to see whether the various standards establishing a patient's fitness were included in the report. The assumption was that "better" reports would explain why a patient was or was not fit (by making reference to standards that are now included in the Code), as opposed to a conclusory statement, without supporting comment, that (simply) "the patient is/isn't fit."

In this exercise, all pre-verdict fitness assessments performed at F.P.I. in the calendar year 1990 (the "pre-Bill C-30 group") were compared to all those performed at F.P.I. in the first twelve months of the new legislation (Feb. 4, 1992 - Feb. 3, 1993). A "fitness assessment" was defined as a case where the referral information on file included a request for fitness assessment, and also cases where fitness was addressed in the assessment but where referral information was missing. Cases where the person initially came in for a fitness assessment but later was certified and had charges stayed (i.e. was diverted into the mental health system) were not included for analysis, since in most of these cases no report to the court was made.[12] Also, cases where the psychiatrist was unable to assess fitness (e.g. where the patient refused, or where the patient was prematurely recalled to court) were not included. This left a total of 207 for 1990 (out of 247 pre-verdict assessments) and 210 for

12. See discussion on this point in previous section ("Issue Number Two").

the first year of Bill C-30 (out of 250 pre-verdict assessments).

"Fitness" was operationalized by using the following standards: (i) can the accused communicate with counsel?; (ii) is the accused aware of the possible consequences of the proceedings?; (iii) is the accused aware of the charge?; (iv) is the accused aware of the roles of the court personnel? (i.e.: judge, prosecutor and defence counsel; the report had to make reference to all three to score in this category). The first two standards, above, are the same as two of the three fitness standards now in the Criminal Code after Bill C-30 (s. 2). The third standard now in the Code -- does the accused "understand the nature or object of the proceedings" -- was subdivided into standards (iii) and (iv) above, borrowing from Bagby's (1992) conceptualization. A report was considered more or less "complete" to the extent that reference was made to one or more of these four standards. The assumption was that reports done after Bill C-30 would be more "complete".

There are a number of deficiencies with this method. First, the fact that psychiatrists may not make reference to fitness standards in their reports does not prove that they are unaware of the standards (although there is some indication, from previous research, that forensic clinicians may have a less than complete knowledge of the legal criteria: see Bagby [1992]). Second, while standards may not be referred to in the reports, one cannot preclude the possibility that these standards were brought up in oral communications (i.e. phone calls to the Crown). Third, one cannot assume that because the standards are not mentioned in the reports that they were not addressed in the psychiatric interview. Notwithstanding these objections, it was assumed for the sake of this study that for a report to the court to be useful, the document itself should make specific reference to the bases of the decision about

fitness.

The results of the content analysis are shown in Table 4. It can be seen from this table that, for both the 1990 and 1992-93 periods, a considerable number of reports were less than complete, i.e. that reference to particular fitness standards were missing. (The heading "all" in Table 4 indicates that all standards were referred to, while "no ref to standards" indicates that no standards were referred to.) Interestingly, however, the 1992-93 reports represent

Table 4. Content Analysis of Fitness Assessments

Time period	Number of cases making reference to fitness standards					
	No ref. to standards	"All"	Commun. with counsel	Conse-quences	Aware charge	Role of personnel
1990 n=207	52 (25.1%)	32 (15.5%)	99 (47.8%)	113 (54.6%)	119 (57.5%)	51 (24.6%)
Feb. 92-Feb. 93 n=210	27 (12.9%)	43 (20.5%)	115 (54.8%)	142 (67.6%)	137 (65.2%)	100 (47.6%)

something of an improvement over the 1990 reports, in that a higher proportion of reports make reference to particular standards, and fewer reports make no reference to any standards. It is difficult, however, to interpret this "improvement", since there are a number of factors -- aside from the impact of the new law -- that might have an effect on the form and content

of the psychiatrists' reports.

As noted earlier in this study (see Issue Number Two) one potentially important factor is personnel, that is, since each psychiatrist may have his or her own reporting style, a change in psychiatric personnel between 1990 and 1992 could account for the overall difference in the contents of the reports.

To account for the personnel factor, a separate analysis was performed holding personnel constant; only the four psychiatrists present in both time periods were compared. The results are shown in Table 5. To protect confidentiality, individual numerical totals are excluded, although individual percentages and overall numerical totals are included.

From an inspection of Table 5, one can note the following. First, it can again be seen that in a majority of cases reports (in both periods) are incomplete. Second, it is noteworthy that there are substantial differences between psychiatrists in how frequently particular fitness standards are addressed (confirming the assertion that the "personnel" factor needs to be taken into account). Both of these findings are similar to those made by Bagby (1992) in his 1992 Toronto study. Finally, it can be seen that, even when holding personnel constant, there was an overall "improvement" between the two periods, in that a higher proportion of the 1992-93 reports make reference to particular fitness standards. Again, it must be said that interpreting this "improvement" is problematic. It is possible, for instance, that over time particular psychiatrists, as they gained more experience and responded to more requests for clarification from the courts, adopted a reporting style that was more congruent with court requests, i.e contained more references to particular fitness standards. On the other hand, it is possible that the legislative changes -- more specific requests for fitness evaluation, and

Table 5. Content Analysis of Fitness Assessments by Psychiatrist

Number of cases making reference to fitness standards

	No reference to standards		"All"		Communicate with counsel		Consequences		Aware of charge		Role of personnel	
	1990	1992	1990	1992	1990	1992	1990	1992	1990	1992	1990	1992
Dr. A	11.3%	5.3%	13.2%	26.3%	49.1%	55.3%	50.9%	81.6%	81.8%	89.5%	20.8%	63.2%
Dr. B	54.5%	31.6%	9.1%	10.5%	31.8%	55.3%	34.1%	47.4%	20.5%	21.1%	18.2%	18.4%
Dr. C	17.8%	0.0%	2.2%	0.0%	35.6%	100.0%	57.8%	83.3%	66.7%	100.0%	8.9%	0.0%
Dr. D	20.0%	17.6%	28.0%	17.6%	56.0%	17.6%	76.0%	47.1%	64.0%	70.6%	48.0%	35.3%
Totals	25.7%	17.2%	11.4%	17.2%	41.9%	51.5%	42.0%	62.6%	58.7%	60.6%	21.0%	37.4%
	(43)	(17)	(19)	(17)	(70)	(51)	(87)	(62)	(98)	(60)	(35)	(37)

Numerical totals: 167 for 1990, 99 for 1992

specific criteria in the Code -- did combine to bring about an improvement in the assessments. In any event, it is noteworthy that the behaviour of some doctors did change over time, that is, that discretionary practices can apparently be influenced -- to some degree -- by external constraints.

Issue Number Four: Shortening the Duration of Fitness Assessments

Prior to Bill C-30, the practice in B.C. was to hold accused persons undergoing pre-verdict assessments for close to the 30 days allowed by the Criminal Code. A study conducted in B.C. in the late 1970s found that accused persons remanded to F.P.I. for fitness assessments were held for 20 days on average (Roesch, Eaves, Sollner, Normandin & Glackman, 1981), and the view was expressed to the author that this figure has lengthened in recent years.[12] Critics have questioned the necessity of a lengthy pre-trial assessment, particularly when many of the accused are found to be fit at the end of the remand; it has been suggested that the remand may in fact be used by the prosecution as a "stalling tactic" (see Ogloff, 1991).

In the new Criminal Code it is stated that assessments to determine fitness, which represent a considerable proportion of pre-verdict assessments, shall not be in force for more than five days (excluding travel time); there is discretion to extend this period, however, where the accused consents, where "compelling circumstances exist", or where the court, the accused or prosecutor feel that more time is needed to complete the assessment (sections 672.14 and 672.15).

I) Interview Results

Archival information on the relative lengths of fitness remands, before and after the passage of Bill C-30, is given later in this section. Working from the assumption that fitness

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12. One of the Forensic staff interviewed for the current study, an individual who had worked at F.P.I. for a number of years, suggested to the author that the length of the psychiatric remand had increased over the years. When asked why this was happening, he stated that he was not certain, but suggested that "administrative practices change over time."

assessments were becoming shorter in duration, the interviews were used to explore two aspects of the "short remand." First, given that a longer (20 -- 30 day) remand had apparently been "necessary" in the past, would the new, shorter remand be "long enough" to perform an assessment? Second, if the longer remand has been used in the past, in some cases, to restore fitness, by treating the individual while in assessment (Addington & Holley, 1987; Lindsay, 1977), does this mean that an "unintended consequence" of the shorter remands will be greater numbers of persons found unfit at the end of the assessment? (This latter hypothesis is examined, quantitatively, in the "Archival Data" section of the Chapter.)

Is five days long enough to do an assessment?

The majority of persons interviewed for this study had the impression that assessments at F.P.I. were becoming shorter in the first year of Bill C-30. Working from this premise, persons being interviewed were asked if a five-day period was long enough to do an adequate assessment on an accused person.

The responses to this question, particularly on the part of the Forensic staff, often involved some consideration of the purpose of the assessment: i.e. was the purpose just to investigate fitness, or should assessments incorporate other issues, such as treatment and dispositional recommendations? The reader may recall that, prior to Bill C-30, the 30-day psychiatric remand at F.P.I. could involve a rather comprehensive assessment of the accused person, including reports prepared by psychologists and social workers.

Briefly, the clear majority of individuals interviewed stated that five days should be long enough -- if the only issue being addressed was fitness.

The majority of the fifteen Forensic staff interviewed (nine) said that five days was

long enough to assess fitness. A smaller number (six), however, suggested that pre-trial assessments should not simply concern themselves with fitness. Several of this group of six went to some lengths to question whether just looking at fitness was a good thing. One commented:

> Before, the Crown would use the psychiatric remand to ask for help in coming up with some dispositional suggestions, you know, "what are we going to do with this guy?" They didn't particularly want to jail him. Now we don't really have the time to address those kind of issues. What you have to ask, though, is: does this (just looking at fitness and not at other clinical and dispositional questions) really help the patient?

In the same vein, another person stated:

> I think that the real purpose of the fitness remand, in the past, was a way to get people off the streets, to get them some treatment. It was a "deal" worked out between the Crown, defence and the psychiatrist. That policy may have to change, however.[14]

This person went on to comment:

> I don't think that the issue of fitness can be separated out from a broader clinical and social assessment. The unfitness, you realize, is "on account of

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14. With respect to the purpose of the fitness remand, and the possible effect of Bill C-30, an interesting communication was noted on one of the police reports on a patient's file. This was the case of a 35-year-old schizophrenic man, charged with a minor crime (food fraud), and sent to F.P.I. on a 5-day fitness remand. The arresting officer had suggested, on his report, that a psychiatric assessment be performed. This request was in fact followed by the Crown, however a prosecutor wrote back to the policeman (on the same report):

> Memo to officer: As of Feb. 4, 1992, the new law in effect regarding mentally ill offenders is Bill C-30. We no longer can get 30 day psychiatric remands. Five day remands are available under the new legislation to determine fitness to stand trial. *In certain cases it may be preferable to deal with the person under the provisions of the Mental Health Act.* (emphasis added)

In short, this quote would seem to offer some (albeit limited) evidence that the psychiatric remand has been used as a way, to repeat the Forensic staff person's quote, "of getting people off the streets", and a suggestion that this practice may change, with other avenues having to be explored, now that remands are shorter.

> mental disorder." We can't just look at fitness and not explore the underlying mental disorder.

The majority of Forensic staff interviewed (thirteen) stated that if pre-trial assessments were not simply concerned with fitness, then five days would not be enough time to carry out a more comprehensive assessment, primarily because of the shortage of staff. One psychiatrist stated:

> We don't have enough staff here, particularly psychiatrists. There is practically no psychiatric coverage on weekends, for instance. A five day remand means, in reality, that the patient is just seen once by the psychiatrist.

An administrator added:

> We have limited psychiatric coverage. The psychiatrists here all work sessions (i.e. are part time). Their time is even more limited now because of the new demands of the Review Board.[15] We will need to hire more psychiatrists.

Another psychiatrist noted:

> It's very difficult with five days to get psychological and social work assessments done. We also have fewer nursing observations to draw from. It means that our work (i.e. reports to the courts) will be more shoddy.

Regarding psychological assessments, a psychologist stated:

> Obviously we can't administer as many tests to patients here on a short remand as we did before. In some cases we're just using a single self-report instrument, just so we have some information on the person. Sometimes you can't get to a person at all, but the psychiatrists know this and will ask for extensions if it's a complicated case. Also, more of our time is taken up with the Review Board now than it used to be.

Similarly, a social worker commented:

> There's no way I can write up all the social histories for the people on five day remands. I still try to get some background information on them, but often I have to relay the information orally to the doctor.

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15. This point is discussed in more detail in a later section in this chapter.

As noted above, a smaller number of the Forensic staff interviewed had some concerns about narrowing the purpose of pre-trial remands to just an assessment of fitness. On the other hand, a majority of Forensic staff stated that, like it or not, this would now be the main purpose of 5-day remands and that, while this meant that assessments would be less comprehensive, they were not meant to be comprehensive now. For instance, one psychologist, when asked if fewer tests were administered to persons on five day remands, answered that "we're not supposed to do a battery of tests, when the only issue is fitness."

Two of the Forensic staff added that five-day fitness remands were a good idea, since in many cases it was quite clear-cut as to whether or not the remanded person was fit (and that in many cases they were fit upon admission), so that a long assessment period was often unnecessary; they added that in more complicated cases extensions of the five days could be asked for. One of these individuals commented:

> Even under the old system of 30 day remands the psychiatrists didn't see the patient that much. In that respect the current situation, where they might just see the guy once, isn't that different from the old situation.

The seven prosecutors interviewed had all had at least some experience with five-day remands, that is, at least two or three cases (admittedly, this does not constitute a great deal of experience in some instances). All seven stated that a five-day assessment should be long enough if the only issue being addressed was fitness. Three mentioned that, while assessments could be extended in more difficult cases, in most cases extensions would be unnecessary. Several commented that while the psychiatric reports may now be less "comprehensive", the ones they had seen so far were adequate for the prosecution's purposes. (A more quantitative evaluation of report composition is given later in this section.) Regarding the purpose of the

remand, the prosecutors interviewed (perhaps surprisingly) played down the idea of the remand being used (primarily) as a means of getting the accused into the mental health system. Further, one stated that "we never used the 30 day remand as a delay tactic." All agreed that the purpose of five day remands should be, primarily, to address the question of fitness.

Of the seven defence lawyers interviewed, six had had at least some experience with five-day remands, that is, had all been involved with at least one case. All seven stated that five days should be long enough to conduct an assessment if the only issue being addressed was fitness. Of the seven, five stated that short assessments would become commonplace; on the other hand two felt that assessments would be routinely extended. (Data on the increase in the number of assessment extensions, following Bill C-30, is given later in the Chapter.) One of the two defence lawyers commented:

> I think F.P.I. will ask for a lot of extensions. They don't seem to have the staffing or the mindset to deal with short assessments. They need more staff. The psychiatrists are all sessionals, they're only there a couple of days a week. They need a change of mindset.

Three of the defence lawyers stated that even under the old system (of 30 day assessments) psychiatrists only saw patients "very briefly", at the "last second" (very end of the thirty days), so that the new system (with psychiatrists apparently being pressed for time) was not all that different. One stated that "they base their assessments more on reading the nurses' notes than examining the patient, anyway." Another commented that

> Really, you could do a fitness assessment in one hour. They shouldn't need all that time. For that matter, you don't even need a psychiatrist; a social worker, or some other trained person could do it.

This person added:

> You can justify a long assessment when you're doing a pre-sentence report, but not at pre-trial. I felt that the old assessments were too expansive, anyway, and could end up helping the Crown's case.

All of the defence lawyers stated that the previous detention periods of 20 - 30 days were inordinately long.

Finally, the Review Board official interviewed stated that five days was enough time for a fitness assessment, and that limiting the assessment to just addressing fitness was probably a "good thing."

Will more people now be found unfit at the end of five day assessments?

As noted above, critics of the old Criminal Code provisions have commented that 30 days was an inordinate length of time for an accused person to be held in custody for a fitness assessment. There is, however, another issue here: in preliminary discussion with Forensic staff the author was told that in some instances 30 days is needed to treat (under the Mental Health Act) unfit, psychotic individuals, in order to restore fitness. Without treatment, such individuals may still be unfit at the end of the assessment which, arguably, is an undesirable outcome in that these persons would be subject to further detention after being returned to court and declared unfit at a fitness hearing. With pre-verdict fitness assessments now becoming shorter in duration, there is some question as to whether there is enough time to restore fitness in cases where the fitness is impaired by an underlying psychosis; this is because antipsychotic medications may take several days, and in some instances several weeks, to produce a therapeutic response (Strayhorn, 1982, pp. 295-296). In short, a possible "unintended consequence" of Bill C-30 is higher rates of unfitness

following psychiatric remand.

To begin with, is there evidence that antipsychotic medication is used to restore fitness? While no direct evidence is available from the present study, it may be noted that antipsychotic medications have been given relatively frequently to persons in pre-verdict assessments at F.P.I. In 1990 and 1991 (combined) 47.0% of persons undergoing pre-verdict assessment (231 out of 491 cases) at F.P.I. were given antipsychotic medications, either voluntarily or involuntarily (i.e. under the Mental Health Act).[16] (It was decided to include 1991 data here, as well as 1990, because information concerning medication was relatively easy to extract from the clinical files: see discussion on "length of comparison period" in Chapter Four.) Of those given antipsychotic medications, 60% (140 out of 231) were returned to court as fit. (The others were either found to be unfit or else had charges stayed while at F.P.I. and were kept on, certified under the Mental Health Act.)

One may also note that there are occasional references to the effects of medications in the psychiatrists' letters to the courts. Three examples of this are the following. Case 1: a 26 year old schizophrenic man is admitted to F.P.I. in 1990 for pre-trial assessment, is treated with antipsychotic medication after being certified, and is returned to court, as fit, after 28 days. The psychiatrist notes: "Treatment has improved his mental state to the point where he can participate in legal matters." Case 2: In 1991, a 37 year old man with bipolar mood disorder is certified at F.P.I., given medications, and returned to court as fit after 29

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16. This information was gathered in a manual file analysis by the author. Each patient file contained a medication sheet, and all patients receiving medications in the antipsychotic or antimania (e.g. Lithium) categories were scored. Drug classification was confirmed by referring to the Compendium of Pharmaceuticals and Specialties (1992) (although most medication names were familiar to the author from previous clinical experience).

days. The psychiatrist states: "Mr. X has had enough antipsychotic medication so that his mental state has improved and he is fit." Case 3: In 1993, a psychiatrist asks for an extension of the length of the fitness remand to 30 days, since, at the end of this period (after the effect of the medications) "he will undoubtedly be fit."

The connection between the shorter assessment period and higher rates of unfitness was addressed in interviews. Persons being interviewed were asked: assuming there is now less time for patients to respond to treatment in assessment, will this mean more people will be found unfit at the end of the assessment?

Briefly, while there was a fair degree of uncertainty on the part of persons responding to this question, a slight majority suggested that the shorter remands would lead to more people being found unfit.

Of the fifteen Forensic staff responding to this question, three were "unsure", three thought that the shorter remands would have "no effect" on the number found unfit, while a majority -- nine -- stated that it was either "possible" or "probable" that more people would be unfit now with shorter remands. From this latter group an administrator commented:

> Before (Bill C-30) we had a bad law but a good result (longer time in assessment, fewer found unfit). Now we seem to have a good law and a bad result (shorter time in assessment, more found unfit).

A psychiatrist added that while there was less time to treat people now, "fitness assessment -- not treatment -- is the main issue now."

Of those who stated that the shorter remand would have no effect, one suggested that "we didn't treat people that much (in pre-trial assessments) with medications (before Bill C-30) anyway", an interesting statement in that it is apparently at variance with the figures

mentioned above. Another person suggested that the reason there would be little effect was that the majority of people coming in for assessments were fit to begin with.

Of those Forensic staff who thought the shorter remand would have an effect, several mentioned complicating factors. Three stated that it was possible that more people would be found unfit at the end of the assessment now, but that this did not mean necessarily that more people would be declared unfit at court and returned to F.P.I. under a disposition order; this was because, according to a nurse:

> I think the courts want to avoid finding the person unfit at a fitness hearing, if possible, since that means the patient would have to come back out to F.P.I. under a disposition order. So, if the person is at F.P.I. and is still unfit after the five day assessment, I think the courts will prefer to just extend the assessment, or readmit the person under another assessment order, so that they may get more treatment out here. Also, there is still the option of staying the charges and having the person stay on at F.P.I. as a certified patient.

A psychiatrist agreed that the courts may try to avoid a finding of unfitness:

> We don't treat people as much in assessment now, and my impression is that more people are returning to court unfit. But I think in a number of instances the courts are treating these people as if they are fit.

Two Forensic staff suggested that one of the important factors in this process was the tendency of the individual psychiatrist involved; a nurse stated:

> Whether or not a person is found fit or not at the end of the assessment depends on the individual psychiatrist. Some doctors have a greater "proprietary interest" in the patient, and will prefer to have the person found unfit (by not treating, or by having a narrower conception of fitness) so that the person will be returned to F.P.I. as unfit and get more treatment under a disposition order. Other doctors lean toward having everyone, if possible, found fit and discharged back to court.

Of the seven prosecutors interviewed, two felt they were unable to comment on this question. The other five had various opinions. Two said it was possible that shorter

assessments would translate into more people being found unfit. One stated that psychiatrists would be unable to treat accused persons in 5-day remands, but was uncertain as to whether this meant that more people would be found unfit. The last two stated that psychiatrists would not want really crazy people going back to court, and so might ask for more time to treat these cases to restore fitness; in this scenario, assessment time would be extended but (presumably) the number of people found unfit would not be affected.

Of the seven defence lawyers interviewed, one felt unable to comment on this question. Of the other six, four said it was "possible" that more people would be found unfit in shorter assessments, with one adding that this meant there would now be more requests to extend assessments. One of the four stated that this latter scenario would only occur in a minority of the cases. The remaining two were uncertain, but suggested that the length of the remand would have little effect since, in their view, people undergoing fitness assessments were not medicated very often anyway (pre Bill C-30).[17]

Finally, the Review Board official did not offer a comment on this question.

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17. In the course of the interviews, several persons suggested that defence lawyers were often against the idea of having their clients certified while in psychiatric remand. It was initially not clear to the author why this should be so, since presumably counsel would want their client's fitness restored quickly. Several explanations were given. Some lawyers were generally dubious about the purpose of the psychiatric remand; some saw certification as giving the doctors excessive control over their clients; and, one lawyer stated that if counsel was planning a defence of NCRMD it was unwise to have the client appear "too good" after remand (which might happen when the psychosis was effectively treated during the assessment) since the credibility of the NCRMD defence might depend on the client appearing disorganized and disordered at court. (Interestingly, the U.S. Supreme Court addressed this last situation in Riggins v. Nevada [1992]. In this case the defendant, who was planning an insanity defence, wanted to go off medications prior to trial so that the court would see his "true mental state", arguing that, otherwise, there was denial of due process. The motion was denied and the defendant was given medication: see Paull [1993].)

II) Archival Data

Archival data were used to examine the impact of Bill C-30 on (i) the length of assessments, (ii) the makeup of assessments, and (iii) rates of unfitness following assessment. Regarding the makeup of assessments, clinical files were examined to see if, as was suggested by some of the interview subjects, assessments were less "comprehensive" following the commencement of the shorter remands. Regarding rates of unfitness, the proportion of persons found unfit following assessment was examined to see if this figure increased following the implementation of Bill C-30.

i) Length of assessments. To examine the impact of Bill C-30 on the length of inpatient assessments, the duration of stay for persons admitted to F.P.I. in the first twelve months of the new legislation (Feb. 4, 1992 - Feb. 3, 1993) was compared with the two preceding calendar years (1990 and 1991). ("Length of assessment" was one of the variables for which a two year "before" period was used: see discussion on "length of comparison period" in Chapter Four.) The results of this comparison are shown in Table 6.

Some explanation of Table 6 is necessary, as it was found that determining assessment lengths was not as straightforward a matter as it might be assumed.

The assessments referred to in Table 6 are pre-verdict assessments (pre-trial or at trial), that is, pre-sentence assessments were not included for analysis; there are several related reasons for this. First, deprivation of liberty may be more a concern for pre-trial cases, where the person has not yet been found guilty of a crime, than for the case where the person has already been found guilty (and may have the assessment period counted as "good time" toward his or her sentence). Second, the new legislation is specifically aimed at

Table 6. Summary Figures on Length of Stay for Inpatient Pre-verdict Assessments, 1990 - 1993.

All pre-verdict assessments (in days)

	1990 n = 211	1991 n = 209	Feb.1992-Feb. 1993 n = 220
Mean	24.7	28.0	19.0
Median	25	27	15
St. Deviation	10.8	16.4	13.5
S.I.Q. range	9	7	19

Pre-verdict assessments, "fitness only", in days

	1990 n = 25	1991 n = 47	Feb. 92-Feb. 93 n = 75
Mean	26.1	27.5	16.2
Median	28	28	13.5
St. Deviation	6.1	10.7	10.4
S.I.Q. range	5	7	15

Note: (a) Pre-verdict assessments in this table do not include cases where patient was certified and charges stayed; (b) "Fitness only" assessments were assessments where, in the 1990 and 1991 files, "fitness" was the only issue requested on the Forensic Services referral form. In the post February 1992 files, "fitness only" meant that "fitness" was the only issue requested on either the Criminal Code referral form or the Forensic Services form, where only one form was present, or was the only issue requested on both forms, where both forms were present. The fact that the "fitness only" "n's" are much smaller for the 1990 and 1991 groups is an artifact of the change in forms, i.e. the older form made it easier to request items other than fitness because of the number of options on the form (see Appendices A and B).

reducing time in custody for persons undergoing assessment of fitness (s. 672.14(2)), which typically occurs at the pre-trial stage; it might be expected that pre-sentence assessments, which are (presumably) broader in scope (Rogers & Mitchell, 1991), and address issues other than fitness, would be less affected (with respect to duration) by the new law. (The number of pre-sentence assessments for 1990, 1991 and Feb. 92 - Feb. 93 were 30, 32 and 45 respectively.)

Further, Table 6 only includes cases where the accused returned to court (as fit or unfit) after the assessment; it does not include cases where the accused initially came in for a pre-verdict assessment but was subsequently diverted into the mental health system; that is, was certified under the Mental Health Act and had charges stayed. This was done for several reasons. First, the intent here was to look at length of assessment for court. Separating out the "time spent undergoing assessment for court" from the "time spent as civilly committed after charges stayed" was impossible in the case of accused persons undergoing diversion, since they were usually certified shortly after admission and in most cases no assessment report for the court was done (i.e. one cannot state when the "assessment" ends and the "diversion" begins). An alternative would be to include the "time spent as civilly committed" in the analysis of length of assessment. There are at least two problems with doing this, however. First, "length of assessment" would be skewed by a relatively small number of civilly committed persons having considerably longer stays than accused persons who return to court. (For instance, the mean length of stay in 1990 for F.P.I. admissions where the patient was certified and charges stayed was 108 days.) Second, in the present study a number of persons being held under the Mental Health Act, and who were admitted in late

1992 or early 1993, were still in F.P.I at the time of the writing of this report, making the calculation of their length of stay problematic. The number of persons diverted into the mental health system are as follows: in 1990, 36 (14.6% of pre-verdict assessments); in 1991, 35 (14.3% of pre-verdict assessments); in Feb. 4, 1992 - Feb. 3, 1993, 30 (12.0% of pre-verdict assessments).

Finally, Table 6 only includes cases where the purpose of the F.P.I. remand was assessment (i.e. of fitness and/or criminal responsibility). It was found that a few of the cases coded as "remand assessment" were in fact instances where the person was being admitted from a pre-trial centre to await trial at F.P.I. (presumably because of deteriorating mental state). The purpose of the admission, in other words, was not to assess fitness and/or criminal responsibility, but to house and treat the individual.

From Table 6, it can be seen that, while length of assessment (after Bill C-30) still may fluctuate to a considerable extent (as reflected by the ranges and standard deviation), there has clearly been an overall drop in the length of inpatient assessments. For all pre-verdict assessments, the mean length of stay went from 28 days in 1991 to 19 in the first year of the new law, while the median (a more useful indicator, given the skewed distributions) fell from 27 to 15 days. Similarly, for assessments where fitness was the only issue requested,[18] the mean length of stay went from 27.5 days in 1991 to 16.2 in the first year of the new law, while the median fell from 28 to 13.5 days. (These figures may also be contrasted with the late 1970s average of 20 days for F.P.I. fitness assessments, reported by

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18. On both referral forms, if both the old and new forms were present, and on the one referral form, where only one was present.

Roesch, Eaves, Sollner, Normandin & Glackman [1981].)

While this is arguably a substantial decrease in the time spent in-custody at F.P.I. for pre-verdict detainees, there is still the question of why the figures are not lower than they are; the median length of stay of 13.5 days for accused persons being assessed for "fitness only" would still seem to be significantly higher than the five day period recommended in the Code. In trying to account for this, the following may be noted:

First, it was found that a number of assessments had been extended beyond the initial court-ordered length of remand. Thirty-six of the 250 pre-verdict assessments (14.4%) conducted in the first year of the new law were extended (following requests from F.P.I. staff). This figure can be compared to the figure of 19 out of 244 (7.8%) pre-verdict assessments extended in the previous year (1991). It is probable that the increased number of requests for extensions in the first year of Bill C-30 had to do with the new, shorter remand periods, since 25 of the 36 extensions were for remands where the initial length determined by the court was ten days or less. Of the 36 extensions, 13 were for cases where the only issue requested for assessment was fitness; the other 23 were for cases where issues other than, or in addition to, fitness had been requested. So, in sum, assessment extensions may partially account for the longer than expected lengths of assessment.

Second, it was found that in a number of instances the accused consented to undergo assessment. In 41 of the 250 pre-verdict assessments conducted in the first year of the new law it was noted on the court order that the accused and/or defence counsel had consented to the assessment. Consenting accused persons may not object to longer remands, and in fact it was found that for consenting persons the average period of assessment requested by the

court was six days longer than in cases where there was no indication of consent on the file: 22.2 days vs. 16.3 days. In the 41 cases where consent was given, ten were where fitness assessment was the only issue requested by the court, while in 31 cases issues other than, or in addition to, fitness were requested. Thus, consent to longer assessment may partially account for the longer than expected lengths of assessment.

Third -- and perhaps most significantly -- an unexpected finding concerning the referring jurisdiction was uncovered. Briefly, it was found that referring courts from outside the Lower Mainland requested longer remand periods than courts within the Lower Mainland.[19] This association is shown in Table 7. From Table 7, it can be seen that the median remand length ordered by Lower Mainland courts, in keeping with the apparent intent of the new law, is quite short: seven days for all pre-verdict assessments, and five days for assessments where fitness was the only issue requested. Conversely, remand lengths ordered by "outlying" courts are considerably longer, even for cases where fitness was the only issue requested. It is notable, for instance, that in 64% of "outlying", pre-verdict assessments, the court-ordered remand length was 25 days or longer. As a further illustration, 19 of 27 "fitness only" outlying remands where no consent was given by the accused were 20 days or longer. In short, the longer than expected lengths of assessment (Table 6) are, apparently, in large part a function of the administrative practices of courts outside the Lower Mainland.

The remaining question is why this difference between regions exists. One commonsensical explanation is that remands need to be longer for outlying regions because

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19. "Lower Mainland" is defined here as all court jurisdictions from Vancouver east to Chilliwack; "Outlying" is defined as all other jurisdictions in the interior of the province and Vancouver Island.

of the greater travel time required; the reader is reminded, however, that the five day period recommended in the Code for fitness assessments is exclusive of travel time (s. 672.14(2)).

Table 7. Length of Assessment Ordered by Court, by Referring Region

	Length ordered, in days			
	All pre-verdict		"Fitness only"	
Region	Mean	Median	Mean	Median
Lower Mainland	11.5	7	7.9	5
Outlying	23.8	28.5	20.9	27

Note: N = 131 for Lower Mainland, pre-verdict; 54 for Lower Mainland, "fitness only"; 119 for Outlying, pre-verdict; 38 for Outlying, "fitness only". "Lower Mainland" defined as all court jurisdictions from Vancouver east to Chilliwack; "Outlying" defined as all other court jurisdictions in the interior and Vancouver Island.

Further, even accounting for travel time, the difference between the Lower Mainland and outlying regions would seem to be excessive. Another explanation (offered by a Crown prosecutor and Forensic Services administrator) is that courts in the outlying areas are less familiar with the mental disorder provisions of the Code and were (at least at the time of this study) maintaining old practices. Unfortunately, given that the interviews conducted in this study were with Lower Mainland -- and not outlying -- personnel, no definitive answer to the question concerning regional differences was uncovered.

ii) Makeup of the assessment. A possible "unintended consequence" of the shorter

remand is the impact on the makeup of the assessment. It was suggested in interviews for this study that pre-verdict assessments at F.P.I., if shorter, might be less "comprehensive" in that there would be less time to conduct social work and psychological assessments of the patient.[20] To examine this matter, and as a simple indicator of the changing makeup of assessments, assessments carried out in the first year of the new law were compared with those in the preceding two years to see what proportion of cases had a written social work and/or clinical psychological report on file. The results are shown in Table 8. It should be noted that this table does not include cases where the patient had charges stayed and was diverted into the mental health system, since in these cases the patient stayed considerably longer at F.P.I. and thus time would be less of a factor with respect to the completion of social work and psychological reports; further, the intent here was to examine the changing makeup of assessments where the accused was returned to court.

As can be seen from Table 8, considerably fewer pre-verdict assessments carried out in the first year of the new law had both social work and psychological reports on file, and considerably more assessments had neither report on file, when compared to the two previous years. This finding would seem to be consistent with the comments made in the interviews that the (on average) shorter remands dictate that there will be less time to conduct these

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20. In requesting extensions of the remand period, psychiatrists would often state in letters to the court that a short assessment period was insufficient to do a proper assessment. One example is a 1992 case where the court ordered a 2 day remand for a fitness assessment of a 42-year-old woman; in requesting an extension the psychiatrist wrote:

> Two days is much too short to do a psychiatric, psychological and social work assessment, or to gather collateral information and prepare documents. Anything less than this is ultimately unfair to the individual receiving the assessment.

ancillary reports. It should be noted, however, that there may be alternative explanations -- other than simply the length of the remand -- for the diminishing number of reports. For one thing, as was stated in the interviews, assessments now more narrowly focused on fitness presumably do not require a battery of psychological tests and a lengthy social history. Further, as will be discussed in more detail in a later section, it may be that psychologists' and social workers' time is taken up more by the new demands of the Review Board than was the case previously. Finally, if the makeup of assessments is changing, the significance of this is a matter of opinion; while some of the clinical and prosecutorial staff interviewed wanted a more "comprehensive" pre-verdict report, others, particularly where the only issue was fitness, saw this as unnecessary.

Table 8. Number of Pre-Verdict Assessments having Social Work and/or Psychological Reports on File, by Year.

	1990 n=211	1991 n=209	Feb. 92-Feb. 93 n=220
Both reports on file	99 (46.9%)	103 (49.3%)	50 (22.7%)
Neither report on file	31 (14.7%)	56 (26.8%)	107 (48.7%)

iii) Rates of unfitness. Another possible "unintended consequence" of the shorter remand is the impact on rates of unfitness. As noted earlier, there is some suggestion that shorter fitness remands might result in higher rates of unfitness, based on the premise that

there is now less time to restore fitness, if necessary, with antipsychotic medication (although the interview comments were equivocal on this matter).

To examine this hypothesis more quantitatively, the rates of unfitness found for inpatient fitness assessments in the first year of the new law were compared with the rates for the previous two calendar years. If the hypothesis is correct, the proportion of persons found unfit after Bill C-30 should rise. The results of this approach, however, must be viewed with caution, since they are only a crude indicator of the "effect" of Bill C-30: whether or not a person is found to be unfit may be influenced by a number of different variables that are unaccounted for here, one variable -- as suggested in the interviews -- being who is doing the assessment.

Rates of unfitness were calculated as follows. For all pre-verdict, inpatient assessments where "fitness" was one of the issues requested by the court, the conclusion about fitness in the psychiatrist's report to the court was noted. As well, cases were also included where there was no referral form, or where there was a form but nothing was checked off, if the psychiatrist addressed fitness in his or her report. "Fitness" was made a dichotomous variable (fit/unfit), so that "marginally fit" was defined as "fit." One complication concerned the fact that some persons undergoing fitness assessments have their charges stayed and are certified and diverted into the mental health system; the problem here is that in most of these cases no report to the court, and thus no conclusion about fitness, is available on the files. To overcome this problem, two calculations of unfitness were made: one calculation deleted the stay/certify cases from the analysis, while the second counted the stay/certify cases as "unfit"; it is conceded that the latter calculation is problematic in that

one cannot necessarily assume that persons who are certifiable are unfit.

The results of the analysis are shown in Table 9. Briefly, what can be seen from this table is that the proportion of persons found unfit (using either method of calculation) is no higher -- and in fact is somewhat lower -- in the first year of the new law than in the preceding year, despite the fact that the median duration of pre-verdict assessments was 12 days less in the first year of the new law than it was in 1991 (see Table 6). While one must be cautious in drawing conclusions from this, the findings appear to contradict the hypothesis

Table 9. Proportion of Persons Found Unfit Following Inpatient Pre-verdict Assessment, 1990 - 1992.

Year	Fit	Unfit	Stay/ Certify	Rate of Unfitness	
				Excluding stay/certify	Including stay/certify
1990 n=218	158 (72.5%)	25 (11.5%)	35 (16.0%)	13.7%	27.5%
1991 n=228	154 (67.5%)	38 (16.7%)	36 (15.8%)	19.8%	32.5%
Feb. 92-Feb. 93 n=216	152 (70.4%)	34 (15.7%)	30 (13.9%)	18.2%	29.6%

Note: rate of unfitness "excluding stay/certify" = number unfit divided by number fit plus number unfit; rate "including stay/certify" = number unfit plus number stay/certify divided by total n, i.e. treat stay/certify as unfit. Table does not include cases where fitness assessments were not completed.

that shorter remands will result in higher rates of unfitness. This would seem to indicate that long fitness remands are not, in fact, "necessary", as a means of restoring fitness. By extension, given the low proportion of persons found to be unfit, this would also seem to indicate that many of the remands are unnecessary, an assertion that has been made for some time by a number of critics of the fitness assessment process (e.g. Roesch, 1977).

Issue Number Five: Performing Fitness Assessments Out-of-Custody

The old Criminal Code did not require that 30-day pre-verdict psychiatric assessments be done in custody, but the practice in B.C. was always to conduct these assessments in a secure facility, namely the Forensic Psychiatric Institute. Critics of this practice have suggested that it is feasible to conduct such assessments in outpatient settings (Ogloff, 1991; Roesch, 1977). The new Criminal Code contains a presumption against custody for persons undergoing assessments, unless "the court is satisfied that on the evidence custody is necessary to assess the accused" (s. 672.16).

An explanatory comment should be inserted at this point. It should be noted that, prior to Bill C-30, persons at the pre-trial stage of the court proceedings were seen on an outpatient basis at B.C. Forensic Services clinics. These cases were not equivalent to the 30-day fitness remands, however; rather, this situation was more analogous to bail supervision. Where a person was seriously disordered, and suspected of being unfit, they would be considered for a 30-day, in-custody assessment. On the other hand, in cases where the fitness issue was not raised, but because of an accused's suspected mental illness some psychiatric involvement was felt to be necessary, individuals could be ordered to attend a Forensic outpatient clinic while out on bail. In these latter cases the accused was usually less seriously disordered.

I) Interview Results

At the time the interviews were conducted, it was evident, despite the presumption against custody in the new Criminal Code, that relatively few outpatient fitness assessments had been conducted (quantitative data are given later in this section). Because of this, persons

being questioned about the outpatient assessment process had to speculate somewhat; in particular, the interviews tended to centre around a discussion of the feasibility of outpatient assessments. Persons interviewed were asked two questions: (i) Would outpatient fitness assessments now become a more common occurrence, and (ii) would outpatient assessments be less frequently utilized in outlying areas, than in major urban areas. The second question was prompted by the observation that forensic psychiatric outpatient resources are limited in the northern areas of B.C., so that, presumably, outpatient assessments will be less feasible in these areas.

Will outpatient fitness assessments become a more common occurrence?

In brief, most of the Forensic staff interviewed suggested that in theory outpatient fitness assessments were feasible, at least in some circumstances, but that the practical problems inherent in this process meant that outpatient assessments might not be commonplace. Significantly, the prosecutors -- who are often the key figures involved in ordering fitness assessments -- did not see outpatient assessments as feasible in practice, and suggested that they would not be used very often.

Of the fifteen Forensic staff interviewed, twelve stated that outpatient fitness assessments should be feasible. Four of the twelve added that it was, in general, "a good idea", with one person explicitly stating that the greater liberty for the accused was an important consideration. This person added that a benefit of the outpatient status was that one could at the same time assess the accused's level of functioning in the community. Two psychiatrists noted that B.C. Forensic Services already had some experience seeing pre-trial patients out on bail (see above). Three persons stated that the number of outpatient fitness

assessments would go up, as the idea "caught on" with judges and lawyers.

These twelve added a number of qualifications, however. A typical comment was: "You can't do as thorough a job with an outpatient assessment, but if the only issue being considered is fitness, then outpatient should be O.K." In the same vein, a number stated that the more seriously disturbed, and persons charged with serious crimes, would be unlikely to get outpatient assessments, and would be sent to F.P.I. A psychiatrist suggested that the court would take into account whether the accused had family and/or community connections in making decisions about pre-trial release (in this sense, following the principles applied in bail hearings).

Three of the fifteen Forensic staff were sceptical as to whether outpatient fitness assessments were feasible. One of this group, a social worker, commented:

> If the person is really mentally disordered, will he be organized enough to make the office appointment? And, if he is organized enough to make the appointment, is he really unfit?

This person added that, in his opinion, the outpatient resources were insufficient, particularly in the outlying areas. (As a counterpoint, it should be noted that several Forensic staff told the author that they could think of cases where a person could be unfit and yet be organized enough to make an office appointment.)

A nurse stated that inpatient assessments were more thorough:

> Some mentally ill people can "pull it together" for a brief office visit, so it might seem that they're doing fine. The advantage of an inpatient assessment is that there is better ongoing observation, so that people can't cover up their symptoms so easily.

Of the seven prosecutors interviewed, one was unfamiliar with the issue and declined comment. Of the other six, three had been involved in at least one case where an outpatient

fitness assessment had been ordered, three had not.

Significantly, of the prosecutors who spoke on this matter, all six suggested that outpatient fitness assessments would be an uncommon occurrence. Four of the six were quite sceptical as to whether they were feasible at all, while the other two stated that they were feasible in some circumstances. One stated that unfit persons were usually too sick for an outpatient assessment:

> You have to understand that, in this court, a fairly high threshold of "craziness" has to be reached before the issue of fitness is brought up. We see a lot of mentally disordered people here, and most of them are channelled through the same way as everyone else. The ones that end up getting assessed for fitness are really sick, and need to be seen on inpatient basis.

Another prosecutor suggested that the courts favoured in-custody assessments:

> In practice it's not that hard to convince the court that the person needs to be seen in custody, for instance if you suggest that he's unlikely to report to an outpatient clinic. Often it's the doctors who recommend that the person be seen in custody, anyway. On the other hand, there was one case where a doctor recommended out-of-custody, but the judge overruled him.

Another prosecutor stated that defence counsel were unlikely to object to in-custody detention:

> You've suggested that persons getting inpatient fitness assessments are being "denied bail." We don't apply the principles of bail when the issue is fitness. Defence counsel aren't worried about their client's freedom at this point; they're more worried about the person regaining fitness.

Another prosecutor suggested that outpatient fitness assessments were more likely to happen in Vancouver, rather than outlying areas, because "Vancouver has more resources" and "the courts there are more used to dealing with the mentally disordered."

Other comments from the prosecutors echoed those made (above) by Forensic staff, i.e.: that inpatient assessments were more thorough (because the doctor could use the nurses'

notes), that mentally ill people were unreliable with office appointments, and that if a person could make an office appointment, was he unfit?

Of the seven defence lawyers interviewed, two stated they were unfamiliar with this issue and declined comment. Of the five who spoke on the matter, three suggested that in most cases outpatient fitness assessments were not feasible because, if the client was "crazy" enough to be unfit, then he or she would usually be too disorganized to manage in the community and make their clinic appointments. Two of the three added, however, that they could envision a few cases where a person might be "unfit but organized"; the example was given of a man who had a fixed delusion concerning the court system but who was, in other respects, quite capable of managing his affairs. One of the three added :

> There aren't enough resources. You would need more clinics around the province. Transportation is also a problem. For people out in the Fraser Valley, it's a long way to go to get to the Vancouver Outpatient Clinic.[21]

The other two defence lawyers stated clearly that outpatient fitness assessments were feasible, could be thorough, and should be done more often. They both added, however, that this might not happen, for some of the reasons already discussed. One of the two stated:

> It's the psychiatrists who always recommend inpatient status. There are people who may be unfit but who can function well enough to make an office appointment. I think the doctors confuse these issues.

The other lawyer stated:

> I don't think there will be many outpatient assessments. If the person has a number of "fail to appears" on his criminal record -- and this is often the case with the mentally ill -- the court won't go for an out-of-custody assessment. I think, however, that the Forensic people are part of the problem. They make it so difficult for the patient to get an appointment at their clinic, you know,

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21. This point is dealt with in more detail later.

> giving them the runaround, or giving them an appointment four weeks down the road that nobody would remember.

Finally, the Review Board official interviewed for this study was not familiar with this particular issue and declined comment.

Will outpatient assessments be more uncommon in outlying areas?

Webster, Menzies & Jackson (1982, p. 19) make the point that requests for psychiatric remands are controlled by "supply and demand." The implication here, and an issue touched on earlier in this section, is that decisions about ordering outpatient assessments (of any type) may well be a function of the availability of resources; that is, outpatient assessments will be less common in outlying areas, where there are fewer psychiatrists and outpatient clinics. Thus, following this logic, persons needing forensic assessment in outlying areas will still be sent down to F.P.I., notwithstanding any presumption against custody in the Criminal Code.

To examine this hypothesis, persons being interviewed were asked if outpatient assessments would be more uncommon in outlying areas.

In brief, this issue apparently had a self-evident quality to it, since the persons stating an opinion in the interviews almost unanimously agreed that outpatient assessments would be more uncommon in outlying areas.

All fifteen of the Forensic staff interviewed agreed that outpatient assessments would be more uncommon in the outlying areas of B.C., and that persons from these regions would continue to be sent down to F.P.I. (in relatively greater proportions) than persons closer to clinical resources. A couple of qualifications were added: one person commented that more Forensic outpatient clinics were opening up in northern B.C., and another person stated that accused persons could possibly be assessed at the local Regional Correctional Centre in their

part of the province.

Of the seven prosecutors interviewed, one was "unsure" about this issue; of the other six, five agreed that outpatient assessments would be more uncommon in outlying areas. One person disagreed, suggesting that local mental health centres could be used as a resource. One prosecutor, who had previously worked in that capacity in a northern B.C. town, commented as follows:

> Up north the Crown may be less aware of the mental disorder provisions in the Criminal Code, I guess because they don't get the volume of cases. It's true that in these areas they will tend to rely more on F.P.I. as a resource. In the town I was in it was very difficult to get someone to examine a mentally ill accused person in a lock-up. There are few psychiatrists available, and I found that the person's G.P. often didn't want to get involved in forensic matters.

Of the seven defence lawyers interviewed, two were "unsure" about this issue, while five agreed that outpatient assessments would be less common in outlying areas; the Review Board official also agreed with this contention. One defence lawyer, while agreeing with the contention, had a somewhat different perspective on this matter:

> Small towns may use F.P.I. more, in my view, because they're more intolerant of deviant people than the larger centres. Shipping them off to F.P.I. is a way of getting rid of the problem. The courts in the smaller centres are more conservative and punitive regarding mentally ill people than, say, Vancouver.

II) Archival Data

The new Criminal Code contains a presumption that fitness and NCRMD assessments shall be done out of custody -- which historically has not been the practice in B.C. (Ogloff, 1991). Accordingly, an attempt was made to gather figures on the number of outpatient fitness and NCRMD assessments conducted in B.C. in the first year of implementation of Bill

C-30.

Unfortunately, limitations in the data retrieval system[22] meant that figures were only available for the Forensic Services' Vancouver Outpatient Clinic, whose catchment area is the Lower Mainland of B.C. While this is obviously a limitation, the following should be noted: first, the catchment area of the Vancouver clinic takes in about one half the population of the province[23], a figure large enough to give some sense of trends in the whole province. Second, responses from the interviews (above) indicated that outpatient fitness assessments are less likely to occur in the outlying areas, because of resource limitations, meaning that -- if anything -- the Vancouver clinic figures may be an overestimate of provincial trends. It might also be noted that, according to the 1991-92 B.C. Forensic Services Annual Report, admissions (case openings) to the Vancouver Clinic constituted 61% of total Forensic Services outpatient admissions in the province.

Briefly, figures from the Vancouver clinic indicate that outpatient fitness and NCRMD assessments were relatively uncommon: only fourteen were conducted at the clinic in the first 12 months of Bill C-30. Six of these were for fitness, five were for NCRMD assessment, and

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22. At the time this research was being conducted the Forensic Services patient information system did not have a code (category) for "outpatient fitness/NCRMD assessment." These assessments were filed in the computer under a generic code that could also include other types of assessments and interventions. Consequently, to get at the outpatient fitness and NCRMD assessments, one had to get a print-out of all cases under the generic code, then conduct a manual file search to isolate the relevant cases (i.e. it wasn't possible to get the information from a computer screen). It was only feasible in the present study to do this for the local (Vancouver) clinic. (See also discussion in Chapter Four.)

23. The 1991 population of Greater Vancouver was roughly 1.52 million (according to Statistics Canada) and the population of B.C. in mid-1992 was roughly 3.3 million (according to figures from the B.C. Ministry of Finance and Corporate Relations).

three were for both fitness and NCRMD. The figure of 14 may be compared with the 250 inpatient pre-verdict assessments that were performed at F.P.I. in the same time period, or 126 inpatient pre-verdict assessments counting only cases referred by Lower Mainland courts, i.e. the catchment area of the Vancouver Outpatient Clinic ("Lower Mainland" is defined here as Vancouver east to Chilliwack). One can only speculate as to whether the proportion of assessments conducted on an outpatient basis will grow with time.[24]

With such small numbers one cannot reasonably comment (at this point) on the "type" of case that is more likely to be referred to the outpatient route. Having said that, the interview comments suggesting that cases involving less serious crimes might be likelier candidates for outpatient assessment prompted an examination of the charge that precipitated the assessment. Not surprisingly, it was found that many of the 14 outpatient cases involved less serious offences; for instance there were five cases of common assault and two cases of mischief. (On the other hand, there was one case of infanticide and one case of sexual assault.)

The relationship between charge seriousness and custody status is shown in Table 10. Criminal charges precipitating pre-verdict assessments in the first year of the new law were categorized using a scheme suggested by Ogloff (1991) and reproduced in Appendix F. Charges were classified as either "minor" (using Ogloff's classification of "minor" offences) or "serious" (collapsing Ogloff's classifications of moderate, serious and major into a single

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24. In addition to the 14 fitness and/or NCRMD assessments, there was one outpatient assessment ordered to determine the disposition of a person already found NCRMD. This is a new category of assessment (s. 672.11(d) of the Code) that is discussed in a later section in this chapter (Hypothesis number seven).

category). In the case of multiple offences, only the most serious charge was used. As can be seen from the table, accused persons sent the outpatient route were more likely to have minor charges than persons sent the inpatient route, although the small numbers make this a tentative conclusion.

Similarly, there is a tentative suggestion that criminal record may affect decisions about in vs. outpatient status. Of the 14 outpatient cases, a majority had no criminal record (eight out of ten, four cases missing), while a majority of the inpatient remandees did have a criminal record (77%, i.e. 186 out of 242, eight cases missing).

Table 10. Association between Charge Seriousness and Custody Status for Pre-Verdict Assessments, Feb. 1992 - Feb. 1993

	Charge Seriousness	
	Minor	Serious
Custody Status		
Inpatient (n=246)	95 (38.6%)	151 (61.4%)
Outpatient (n=14)	9 (64.2%)	5 (35.8%)

Note: (a) "Charge seriousness" determined by scheme shown in Appendix F; (b) four missing cases from inpatient group not included in analysis.

Issue Number Six: Protecting Accused Persons from Self-Incrimination During Psychiatric Assessment.

In Canada, there has been some concern that the pre-trial psychiatric evaluation process may potentially be incriminating to the accused, since the psychiatric report is accessible to the Crown, and may deal with the circumstances of the offence. Some persons critical of this process have suggested that the psychiatric remand may be deliberately used by the Crown as an information-gathering device (see Ogloff, 1991). To deal with the fact that psychiatrist-accused communications were not protected in the Criminal Code (prior to Bill C-30), some jurisdictions apparently developed a policy of not asking the psychiatrist to provide "fact" information to the Crown, based on what was said by the accused (Butler & Turner, 1980).

In an apparent response to these criticisms, the new Criminal Code contains a provision for "protected statements": section 672.21 states that communications from an accused during a psychiatric assessment are not admissible in evidence, without consent, before a court or tribunal. This provision is rather ambiguous, however, in that the Code gives a number of exceptions to the "inadmissibility" rule. Notably, a statement is admissible if it is used to help determine (i) fitness to stand trial; (ii) where the accused raises the issue, whether he or she qualifies for an NCRMD defence; (iii) whether statements made at court are inconsistent with those made in assessment.

In exploring the impact of the "protected statements" provision, information from

interviews (only) was used.[25] The question was aimed at determining how the new provision would affect court proceedings, therefore it was decided to only ask this question of legal personnel, not Forensic staff.[26]

Interview Results

Will the "protected statements" provision in fact give greater protection to accused persons in pre-verdict assessments?

Persons interviewed for this study were asked if the new provision for "protected statements" would mean that accused persons undergoing pre-verdict assessment were now protected to a greater extent from self-incrimination.

In brief, a large proportion of persons responding to this question were uncertain as to what impact the "protected statements" provision would make. Notably, however, several defence lawyers had the perception that the provision still left room for self-incrimination.

Of the seven prosecutors interviewed, three were "unsure" as to whether this provision would have any practical effect; one person said that it was "up in the air" as to how the provision would be interpreted. Another of the three added that there were some "inconsistencies" inherent in the "protected statements" provision; this person stated:

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25. An archival analysis of this provision would require access to court documents, which the author did not have. There was very limited information pertaining to this provision in the clinical files; from discussion with Forensic Services staff it was determined that discussion between the psychiatrist and the accused pertaining to privileged communications was not consistently reported in the psychiatrist's letter to the court.

26. In retrospect, however, it would have been useful to have asked clinical personnel whether this new provision affected the way pre-trial assessments were conducted, with respect to the topics addressed by the psychiatrist in the assessment (see discussion on this point later in this section).

> The law supposedly "protects" the accused's statements, but the fact remains that you can still admit statements concerning fitness, possibly concerning the state of mind at the time of the offence, and also if the accused contradicts himself at court. I would worry that with those exceptions, there is still the potential for self-incrimination.

Of the other four prosecutors, one stated that the "protected statements" provision would have no practical effect; this was because:

> We never abused the system (of psychiatric remands) before, anyway. We didn't use it to gather information on the accused to be used at trial. Even under the old system, the courts were reluctant to admit information from the psychiatric assessment.

The remaining three prosecutors all stated that the provision did offer greater protection from self-incrimination. All three suggested that statements would now only be admitted to test the credibility of the accused at trial, by looking at inconsistent testimony. One of the three added that this wouldn't happen, anyway, unless the accused took the stand. This person also made the following comment:

> In the past we were able to use statements made to a psychiatrist as if they were made to a police officer. Sometimes these statements were used at trial. Now, there will be less chance of this happening.

This person added that psychiatric remands were not used deliberately for this purpose(information gathering), however. Interestingly, one of the three suggested that the "protected statements" provision meant that psychiatric assessments could deal more now with the circumstances of the offence, since this information couldn't be used to incriminate the accused -- although it could be used to test the credibility and consistency of the accused's testimony.

With the exception of the one prosecutor quoted above, none of the prosecutors saw the new provision as having built-in inconsistencies leading -- still -- to potential self-

incrimination.

Of the seven defence lawyers interviewed, four stated that they were "uncertain" as to whether or not the "protected statements" provision would offer greater protection against self-incrimination. One of these four thought that the Crown would still try to use the psychiatric assessment as an information-gathering device. Two of the four stated that they were concerned that, notwithstanding the new provision, statements made to a psychiatrist could still be used indirectly against an accused; one of the two gave the following explanation:

> The assessment could still give the police information that would lead to something else. Suppose the accused told the psychiatrist that he used a weapon in the offence, and then told him where he dumped the weapon. The police then go out and find the weapon. What the accused told the psychiatrist might not be admissible, but if the police produce the weapon, that -- the physical evidence -- could be admissible.

Of the other three defence lawyers, two suggested that the new provisions did offer greater protection against self-incrimination, although one of the two added a reservation; this person stated:

> The Code says that statements can only be introduced to challenge the credibility of the accused, by looking at contradictions between what was said to the psychiatrist and what is said in court. If there are contradictions, this shouldn't be taken as a confession to the crime -- in effect -- but I would be worried that the jury might interpret it that way, despite what the Code says.

Both of these lawyers, while generally positive about the "protected statements" provision, added that the situation would likely not change greatly because there had always been (in their experience) limits placed on the admissibility of information gathered in psychiatric assessments, regardless of whether any limits were articulated in the Code.

Finally, one defence lawyer held the perception that the "protected statements"

provision had made the situation worse. This was explained as follows:

> Before (Bill C-30) we had an agreement that statements made to a psychiatrist wouldn't be used against the accused. The courts didn't want psychiatrists to be policemen. Now, what can be done is set out in the Code, but in my opinion the provisions aren't that helpful; the provisions still leave a lot of openings for cases where some statements could be used against the accused. Consequently, I'm telling my clients not to say anything to psychiatrists in assessment.

In sum, there was disagreement among the lawyers interviewed with respect to the impact of the "protected statements" provision. This disagreement likely stemmed from the fact that the lawyers interviewed had had little direct experience with the new statute. The disagreement may also have had to do with different perceptions of how the psychiatric remand had been used in the past, with some persons feeling it had been used "fairly" while others feeling it had been used unfairly, by the prosecution, as an information-gathering device.

Issue Number Seven: Increasing Numbers of Court-Ordered Assessments

While perhaps not immediately obvious, one of the anticipated "side effects" of Bill C-30, as related to the author in preliminary discussion with Forensic Services staff, was that the volume of court-ordered assessments would increase (above and beyond any natural increases due, for instance, to population growth). There are at least three reasons to believe why this should be the case.

First, there is at least one new category of assessment in the Criminal Code that did not exist before: an assessment may now be ordered to determine the appropriate disposition of persons found to be unfit or NCRMD.[27] Previously, no assessment was done in such cases; rather, the accused was automatically detained under a lieutenant governor's warrant; now (presumably) the court may want further assessments to determine if other (out of custody) dispositions are available.

Second, the forensic assessment process is (arguably) less onerous than was the case previously. This is because there is now a presumption in the Code that pre-verdict assessments shall be done out of custody and shall be of short duration (see Hypotheses Numbers Four and Five above). If judges, defence counsel and/or the Crown perceive the process to be less onerous, it is possible that they might be more willing to utilize the forensic assessment process.

Third, the consequences of the assessment process may now be less onerous. Previously, if found unfit or NCRMD, the consequence was automatic indeterminate

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27. There is in fact another category of assessment as well: to determine whether or not a hospital order should be made (s. 672.11(e)). At the time of this study, however, the hospital order provision had not yet been proclaimed.

detention. Now there is (presumably) greater possibility of out-of-custody dispositions. In particular, with the possibility of conditional or absolute discharge unless deemed to be a "significant threat" (s. 672.54(a)), accused persons may find the NCRMD defence a more attractive option, and assessments of criminal responsibility may increase.

I) Interview Results

To explore these issues, persons interviewed for this study were asked two questions: (i) In general, do you think that the number of court-ordered assessments will increase after Bill C-30? (ii) More specifically, is it possible that more fitness assessments will be ordered because judges will perceive that the assessment process is less onerous (i.e. only five days in duration, vs. thirty)? The issue of whether NCRMD assessments will be utilized more frequently, while touched on in these questions, will be addressed in more detail in a later section in this chapter (see "Issue Number Ten").

In commenting on any potential increase in assessments, persons were reminded that this question concerned the effects of Bill C-30, since there could be other factors -- unrelated to Bill C-30 -- that could influence the number of referrals (e.g. more mentally ill people in the community).

Will the number of assessments increase?

In brief, many of the persons responding to this question were uncertain as to whether there would be an increase in court-ordered assessments after Bill C-30. Most of the Forensic staff had the impression that, in the first year of Bill C-30, there had been no increase in referrals from the courts, and several suggested that there had been an initial decline in the number of referrals; it was added, however, that the decline was likely an anomaly, due to

the courts' unfamiliarity with the new legislation. Those persons suggesting there would be an increase in referrals commented that this would possibly be a consequence of the NCRMD defence being raised more frequently.

In answering this question, the Forensic staff interviewed first commented on whether, at the time of the interview, the number of referrals from the courts had increased perceptibly, and second, whether the number of referrals would increase in the future.

Of the fifteen Forensic staff interviewed, only three suggested that the number of court ordered assessments had increased since Bill C-30; the other twelve stated that they had not perceived any noticeable increase in the volume of assessments.

Several staff (six) commented on the fact that there had in fact been, apparently, an initial drop in the number of assessments, immediately following the implementation of Bill C-30. There were essentially two explanations offered for this drop. First, it was suggested that the courts were not yet familiar with the new legislation, and had (apparently) avoided dealing with it. One person went on to say that:

> With any new piece of legislation there is a period of unfamiliarity, where people pull back from using it. Once the judges and lawyers figure out how the system works, there will be an increase in the number of referrals.

The second explanation for the drop was that, apparently, "the courts were afraid of overloading the Forensic resources." One person interviewed recalled seeing a letter sent out to all Crown prosecutors -- written by a Vancouver Provincial Court Crown Counsel -- requesting that the Courts not overload F.P.I. with new referrals.

When asked if, in the future, there would be an increase in court referrals due to Bill C-30, six Forensic staff persons suggested that there would be, while nine stated that they

were uncertain. One person suggesting an increase commented that an eventual increase was self-evident, in that there were new reasons for assessment now given in the Criminal Code; this person pointed out, as an example, that assessment of mental state at the time of the offence was now explicitly recognized in the Code.[28]

Three of the Forensic staff mentioned a factor that would mitigate against an increase in the number of court ordered-assessments done in inpatient settings (F.P.I.) or outpatient settings: these persons suggested that there was now better screening going on in the brief, preliminary assessments being done at jails or pre-trial centres. A psychiatrist explained this as follows:

> Before, in the jail assessments, we mainly looked at the mental state of the accused, not so much the fitness. As you know, a 30 day remand could be ordered on this basis (some question about the accused's mental state). Now, we're looking more closely at the fitness question at jail. We're screening out more people who are fit, notwithstanding their mental state. Also, sometimes if the accused is clearly unfit, we may go directly to a fitness hearing, without a further inpatient assessment being ordered. So, in effect, the jail assessments are in some cases taking the place of the assessments that would have been done before at F.P.I.

The prosecutors and defence lawyers interviewed on this issue for the most part had had less direct experience (concerning exposure to figures on the number of assessments) than the Forensic staff. Because of this, their responses dealt more with what they thought would happen in the future, and less with what had happened.

Of the seven prosecutors, five were "uncertain" whether or not Bill C-30 would lead to more court-ordered assessments; the other two suggested that there would not be an

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28. While it is true that "assessment to determine mental state at time of offence" was not explicitly mentioned in the old Criminal Code, such assessments (at pre-trial) were (as noted earlier) requested by the Crown in B.C. prior to Bill C-30.

increase. Of the five stating they were "uncertain", three added that it was "possible" that there would be more assessments, with all three suggesting that this might be due to an increase in the use of the NCRMD defence (and thus an increase in NCRMD assessments). One of this group stated:

> Previously, a lot of judges would prefer the accused to plead guilty at their first appearance if it was a minor charge. Then they would be given an absolute or conditional discharge. Now, with the change in legislation (concerning length of remand and "attractiveness" of NCRMD defence) defence lawyers may be more disposed to considering a psychiatric remand.

Of the two persons suggesting "no increase", one echoed the comments of the psychiatrist quoted above -- concerning fitness assessments -- by stating that "In Vancouver there is better screening of mentally disordered persons at the pre-trial centre, with the option of going straight to a fitness hearing" (without any F.P.I. assessment). This person added, however, that in outlying areas, where there were fewer psychiatrists available, the courts would still rely on sending mentally disordered persons down to F.P.I.

Two of the prosecutors commented on the (apparent) initial decline in referrals to F.P.I. One said this was a "fluke"; both suggested that this had to do with judges and prosecutors being unfamiliar and uncomfortable with the new legislation, and thus avoiding using it.[29]

Of the seven defence lawyers interviewed, four were "uncertain" as to whether Bill C-30 would lead to more court-ordered assessments. Of the other three, one stated that there was no reason why there should be any increase. On the other hand, the other two defence

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29. As an aside, it might be noted that one of the prosecutors interviewed suggested that dealing with the Criminal Code provisions for mentally disordered persons was, for that individual, one of the most complex, cumbersome and unsatisfying aspects of the job.

lawyers suggested an increase was "possible', and that this would likely be due to an increase in NCRMD assessments.

Finally, the Review Board official interviewed suggested that an increase in assessments was "possible", and that this might be linked to an increase in NCRMD assessments.

Will judges be more likely to order fitness assessments because the assessment process is now less onerous?

As noted earlier in this section, one of the reasons given for a potential rise in court-ordered assessments, after Bill C-30, was that the process might be perceived to be less onerous for the accused, i.e., whereas before an accused might spend 20-30 days in-custody for a psychiatric remand, now the period was (presumably) shorter -- five days, for fitness assessments. The implication here is that judges might have been reluctant to order remands before, feeling (perhaps) that 30 days in-custody was an inordinate deprivation of freedom. To look at this issue, persons interviewed were asked if judges would in fact be more likely to order in-custody fitness assessments after Bill C-30, knowing that time in custody was shorter.

Unfortunately, this question (like a number of others) produced a large proportion of "uncertain" responses and no clear consensus from the persons interviewed. Of those stating an opinion, a slight majority suggested that an effect of the shorter fitness remand would conceivably be an increased use of the remand. Notably, several of the persons interviewed suggested that whether or not a fitness remand was ordered often was primarily a function of the particular judge involved, with some being prone to using remands, and some not --

regardless of the length of the remand.

Of the fifteen Forensic staff interviewed, ten stated they were "uncertain" as to whether judges would be more likely to use a shorter fitness assessment. Of the other five, two stated that this was possible, that judges would take the five days into account in deciding whether or not to make an order. On the other hand, three suggested that the shorter remand would make "no difference"; one of the three said: "I'm not convinced that the courts worry too much about "onerousness" when they're making these sorts of decisions."

The prosecutors and defence lawyers were somewhat more positive in their answers to this question. Of the seven prosecutors, three stated that it was "possible" that judges would be more likely to use a shorter fitness remand. One of these three explained this as follows:

> A lot depends on the individual judge, but it is true that some judges don't like ordering fitness remands. They would rather have the accused make a plea, particularly if it's a minor charge, then give them a conditional or absolute discharge. It's possible that these types of judges might be more disposed to ordering fitness remands now that the period is only five days.

Of the other four prosecutors, three were "unsure" as to whether the shorter remand would make any difference, while one stated that the length of remand would make "no difference"; this last individual stated that: "'Onerousness' isn't taken into account when deciding whether or not to order an assessment."

The breakdown of responses from defence lawyers was similar to the prosecutors': three defence lawyers stated that judges would possibly take the shorter remand into account, three were "unsure", and one stated that the length of the remand would make "no difference" in whether or not fitness assessments were ordered. One of the three suggesting

there would be a difference stated quite emphatically that judges did consider "onerousness" in their decisions.

Finally, the Review Board official interviewed was "uncertain" as to the effect of the shorter remand.

II) Archival Data

In examining the volume of assessments in the first year of the new law (i) the overall numbers, (ii) the use of new categories of assessment and (iii) the use of NCRMD assessments were considered.

i) Overall numbers. The total number of assessments performed at F.P.I. in the first year of the new law was 295 (250 pre-verdict and 45 pre-sentence). This represents a 6.8% increase over the figure of 276 for the 1991 calendar year (244 pre-verdict assessments and 32 pre-sentence), and a 6.5% increase over the figure of 277 for the 1990 calendar year (247 pre-verdict assessments and 30 pre-sentence). It is too early to tell, however, whether this is an indication of a substantial, or lasting, increase in the number of assessments following Bill C-30. Any increase in the number of assessments could be at least partly explained by increases in the general population, or in the number of crimes committed in the province. Regarding the amount of crime, it should be noted that crimes known to the police (lumping together all categories) have been increasing both in absolute numbers and as a rate in B.C. through the 1980s and into the early 1990s (B.C. Ministry of the Solicitor General, 1992).

On the other hand, there are several pieces of evidence consistent with the hypothesis that Bill C-30 will result in an increase in the number of assessments. First, there was found to be, in the first year of the new law, an increase in assessments specifically concerning

criminal responsibility, which was one of the predicted consequences of Bill C-30 (see Chapters One and Three); this point is discussed further below.

Second, the figures given above, on the number of assessments, concern only inpatient admissions. Since fitness and NCRMD assessments may now be performed out of custody, any discussion of increasing assessments must incorporate outpatient assessments as well. Unfortunately, as described earlier, it was not possible to get precise figures on outpatient assessments for the whole province. Using just the figures from the Vancouver Outpatient Clinic it was found, as noted earlier in this chapter, that there were 14 fitness and/or NCRMD assessments performed at the clinic in the first year of the new law. Adding this number onto the number of inpatient assessments gives a total of 309, an increase of (at least) 12.0% over the number of assessments performed in 1991.

Third, the figures for the first year include a period right after the law was implemented (around March, 1992) where there was a "dip" in F.P.I. admissions. This is shown graphically in Figure 1. It was suggested, in the interviews, that this "dip" was due to the courts' unfamiliarity with the new legislation. As can be seen from Figure 1, monthly admissions did pick up following this temporary decline: a possible implication of this is that greater familiarity with the new provisions may lead to greater utilization. However, the possibility that the dip was due to random, monthly fluctuations -- while seemingly unlikely -- cannot be ruled out.[30]

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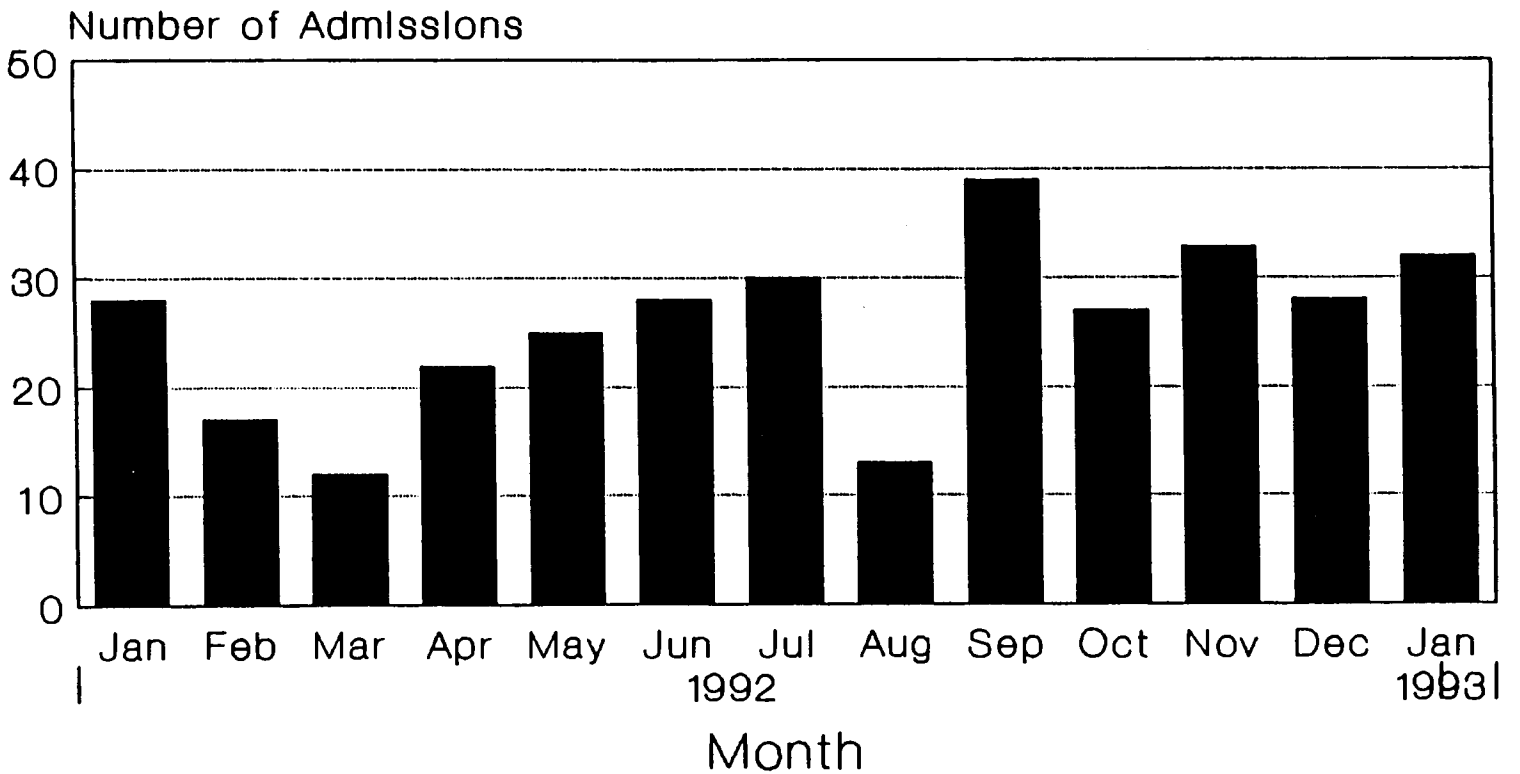
30. There are, indeed, monthly fluctuations in referrals to F.P.I. In 1991 the monthly low for referrals was June (13 referrals) and in 1990 was October (17 referrals). The "dip" in March of the first year of the new law is not apparently due to a consistent seasonal variation, however: the totals for March for 1990 and 1991 were, respectively, 22 and 24.

Fig. 1. F.P.I. assessments, by month.



ii) New categories of assessment. As noted earlier, there is a new category of assessment under Bill C-30, namely, assessment to determine disposition for persons found unfit or NCRMD.

Briefly, it was found from looking at assessments performed in the first year of the new law that this category was used very infrequently. In only one case of the 295 pre-verdict and pre-sentence assessments performed at F.P.I. was this category the sole reason for assessment. In six cases this issue was added on to other issues being requested for assessment (e.g. fitness or NCRMD). Thus, at least in the first year of Bill C-30, this particular category of assessment was seldom used. As for why it was seldom used, one can only speculate. It may have been due to unfamiliarity with the new provisions; it may also suggest that the courts are reluctant to make the initial dispositions for unfit/NCRMD persons themselves, and would rather relinquish jurisdiction to the Review Board.

iii) Use of NCRMD assessments. As was suggested in the interviews, there is a perception that requests to assess criminal responsibility will increase after Bill C-30, primarily because the consequences of being found NCRMD are less onerous under the new law. This subject -- the NCRMD defence as a "more attractive option" -- will be discussed in more detail later in this chapter (see "Issue Number Ten"). Briefly, however, for the purposes of this section, it can be said that there is some evidence that assessments of criminal responsibility increased in the first year of the new law. More specifically, it was found that assessments conducted by B.C. Forensic Services that only looked at NCRMD (and not fitness) increased from 12 in 1991 to at least 32 in the first year of Bill C-30. The "at least 32" refers to 27 assessments done at F.P.I. and five done at the Vancouver

Outpatient Clinic; data from other outpatient locations was not available. There are a number of methodological issues that must be considered when interpreting these figures; to avoid redundancy these issues will not be discussed here, but rather will be examined in "Issue Number Ten", later in this chapter.

Issue Number Eight: More Procedural Protections for Mentally Disordered Accused Persons in the Disposition Review Process

With the passage of Bill C-30, the role of the Review Board has been significantly changed. The Board is no longer an advisory body to the provincial cabinet, but rather operates more as an independent tribunal. Whereas formerly hearings were relatively brief, informal, and non-legalistic, there is now greater emphasis on the due process rights of the accused, notably, right to counsel and access to clinical information. There is a presumption against in-custody detention of persons found unfit or NCRMD, unless there is some indication that the accused is a danger to the public.

In examining the nature of the review process, interview information (only) was used in the present study. A quantitative analysis was not attempted for several reasons. First, the author did not have access to Review Board records (this had been requested, but was not granted by the completion of the project). Second, an observational study of the review hearings was not attempted: it was felt that such a study, done properly, would have been prohibitively time consuming (indeed, such an approach might constitute the basis of a separate study). Third, some of the issues of interest -- such as the relationship between the hospital and the board, or between clinical staff and patients -- are not, strictly speaking, amenable to quantitative analysis. It is conceded that the information gathered in this section merely touches upon some issues that could be clarified by further quantitative and qualitative study.

Interview Results

Interview subjects were asked: (i) How the nature of the Review Board hearings had

changed, if at all, after Bill C-30, and, (ii) how these changes impacted on the way people carried out their jobs. It can be seen that these questions are rather broad and open-ended; this was due to the fact that, coming into the study, the author was frankly little aware how -- or if -- the changes in the law would affect this area. (In a comment on the Ontario situation, for instance, O'Mara [1991, p. 84] suggests that there will be "little difference in the operation of the Board of Review from the pre-Swain to the post-Swain phase.")

In brief, it quickly became apparent from the interviews that (i) the nature of the Review Board hearings had changed substantially in B.C. after Bill C-30, and (ii) these changes would have a significant impact upon the administrative practices of the B.C. Forensic Services. A number of people went on at great length in discussing this topic, and it is probably fair to say that this issue was the most contentious one addressed in the study. In reading the interview results, it should be noted that the respondents with the greatest involvement with the Review Board were Forensic Services staff; most of the defence lawyers and prosecutors interviewed had had less experience dealing with the Board. Further, it may be said, in retrospect, that it would have been desirable to have had greater participation, in the interviews, from Review Board members themselves. For clarity, results are presented below, separately, by occupational group.

A) Responses from Forensic Services Staff

The comments offered by the Forensic staff were wide-ranging; there were, however, a number of recurring (overlapping) themes, which are presented separately below:

(i) Hearings more legalistic and adversarial. Most of the Forensic staff interviewed suggested that the Review Board hearings, which previously had been informal and

inquisitorial in manner, were now following a judicial model, like a "high court" according to one nurse. One staff person commented:

> Before, the patient usually didn't have a lawyer present at the hearing, and neither did the hospital. The only lawyer in the room might be the one on the Board. Now the patient always has one, and often there are lawyers there representing the hospital and the Attorney General. Obviously, there's a lot more legal wrangling. The hearings are much more tense and formal now. The patient is in fact referred to now as "the accused", not "the patient." You swear on bibles, there is cross-examination, a lot of attention to procedural matters. You have to defend everything you do, your treatment of the patient, and your recommendations about release. They (the Board and counsel for the accused) will question every word in your report. You have to be very specific, document everything, and provide support for any statement you make.

(ii) Hearings now longer. All Forensic staff interviewed stated that the Review Board hearings were now much longer than they had been before. Previously a case might take 30 minutes to an hour; now, the author was told, they could take several hours, or even several days if it was a "high profile" case. A nurse case coordinator stated that before Bill C-30 hearings were held for one day a week; now they were going four to five days a week.

(iii) Need for more manpower. Most of the Forensic personnel interviewed stated that the review process took up much more staff time than was the case previously. Psychiatrists, psychologists and social workers had to prepare more detailed reports for the hearings; reports now had to more explicitly justify decisions and actions taken by hospital staff involving the accused. Further, psychiatrists may now be subpoenaed to appear at the hearing -- which never happened before -- and which would mean an extra financial burden for the Forensic Commission.[31] A number commented that more staff would have to be hired to deal

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31. The author was not given the impression, however, that (at the time of this study) many psychiatrists had actually appeared in the hearings. The question of whether, and how many,

with the demands of the review process. It was reported that some hiring had already begun: the contingent of nurse case coordinators (the people who represent the hospital at the hearings) had been doubled from three to six in 1992. A nurse stated further that "legal training may have to make up a greater part of the nursing curriculum."

(iv) Greater access to information; change in recording practices. The patient and his or her counsel have greater access to clinical reports than was the case previously. Before, while a summary report would be given at the hearing, the patient's access to his or her file was restricted. Now, as a nurse case coordinator stated, "every word in the file can be accessed by the patient." A nurse commented that "there seems to be much more verbatim reading out of nurses' notes at the hearings, in front of the patient, with our names attached." Another nurse noted that patients are given copies of the review hearing reports, whereas before they were not.

Most of the Forensic staff interviewed commented that the greater access to information by the Board, the patient and/or counsel, had forced a change in the way clinical staff wrote notes in the patient's file -- a "constriction", as one nurse put it. One staff person stated:

> You have to be very careful with what you write in the patient's chart now. You can't use any pejorative terms. You have to be very specific, and back up any statements you make. If you say something like "he's psychotic", you have to support that with evidence, since their (the Board) attitude seems to be that you have to show proof for everything.

A psychologist commented:

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psychiatrists had appeared at hearings was not addressed in the present study.

> For me, one of the biggest impacts of the Criminal Code changes is the way I write my reports. Since more people have access to them now, I have to make sure I don't write anything that would upset the patient if he reads it. Also, since in effect I'm writing for a lay audience, not a professional one, I may have to take some data out or simplify it in case it's misinterpreted.

Lastly, one Forensic staff person suggested that the clinical notes had become more "sterile".

(v) "Least restrictive disposition" stressed over need for treatment. Forensic staff interviewed stated that, as required by the Criminal Code, the Review Board was now taking the position that patients should receive the "least restrictive disposition", and thus be given conditional or absolute discharges as early as possible. A nurse case coordinator stated that: "There's clearly a presumption against detention; the board's attitude is, 'if he's not dangerous, why are you keeping him?'." A psychiatrist commented that: "Before (Bill C-30) it seemed that we had to argue (at the hearings) for the guy's release; now we have to argue that he should be detained to receive more treatment."

While acknowledging that dispositions under the old system could be onerous, three Forensic staff stated that with the emphasis on "dangerousness" the patient's need for treatment was now being completely overlooked. One of these persons stated:

> The lawyers don't understand clinical issues. They're not qualified to make these sorts of decisions. A patient can be making a slow recovery, doing O.K., then the Review Board intervenes and discharges him before he's ready. I really don't think they're helping him by doing this. Before we had a balance (between civil rights and clinical discretion); now the pendulum has swung too far in favour of the "new legalism."

Another staff person concurred, stating that "From a clinical perspective, I don't think this process is serving the patient's interests." Another individual stated that it was "more likely now (than before Bill C-30) that the Board will go against medical advice." (The issue of patient dispositions is addressed in more detail in a later section in this chapter. See

"Issue Number Nine.")

(vi) Traditional clinical role "eroded". A majority of the Forensic staff suggested that the Review Board was intruding more into clinical matters, and going against medical advice more often than was the case previously. Five individuals suggested that the greater access to information, the emphasis on civil rights, and the intrusion into clinical matters meant that the clinical relationship (between staff and patient) was being undermined or eroded. A psychiatrist stated that there was "a greater distance between staff and patients now" and that "the helping role is no longer there.". A nurse commented that "I'd like to go back to being a nurse, and stop having to worry about being a lawyer."

(vii) Problems with predicting dangerousness. Four forensic staff suggested that a particular concern in the new system is the prediction of dangerousness, since, it was suggested, the hearings often boiled down to a question of whether or not the patient could be considered to be a "significant threat to the safety of the public" (as per the Criminal Code). An administrator stated that: "Dangerousness is now the big issue, the key criterion." This individual added that the Forensic Psychiatric Commission was being put on the spot because of this, in that there could be the question of liability (if the patient reoffended when released) and given the well-known difficulty, and reluctance on the part of some psychiatrists, in predicting future behaviour.

Three of these staff noted that, in response to this concern, a risk assessment protocol was (at the time of the interviews) being developed, and that a consultant familiar with such protocols had been hired. The nurse case coordinator suggested that, with respect to risk assessment, instruments such as the Psychopathy Checklist (Hare, 1990) would now be relied

upon to a greater extent (whereas before more purely clinical assessments were the norm).

(viii) Relationship with Board to evolve over time. A final issue that arose out of the Forensic staff interviews was the view (offered by five individuals) that while their relationship with the Board was going through "growing pains" in 1992, it would likely evolve, with time, into a more stable, agreeable one. One staff person noted that "we're still in a reactive phase right now". An administrator commented that it was (at the time of the interviews) something of a power struggle between the Board and the hospital, but that when procedural and policy matters were clarified things might improve.

In summary, the interviews with Forensic staff suggest that the review hearing process has changed significantly in B.C. after the introduction of Bill C-30. The issues are complex, and one must be careful not to overgeneralize; however, it would be fair to say that a number of the Forensic staff interviewed felt uncomfortable with the changes -- for the various reasons outlined above. This is, of course, not surprising in that the changes were sweeping, and brought in abruptly.

It should be noted that four of the Forensic staff interviewed went to some lengths to indicate that they agreed with the intention of the new legislation -- to maximize the civil rights of accused persons -- and believed that the situation of persons found NGRI and unfit in the past was clearly too onerous. One individual stated that the old legislation was "Draconian", but added that the change process had been "painful" and that Forensic staff had been treated with a lack of respect -- being suddenly made subordinate to the Review Board, with this latter body (apparently) under-valuing the opinions of the clinical staff. A second person commented that:

> The new chairman of the Review Board wants the Board to be seen as clearly separate from the hospital. It is possible that we were too "chummy" in our dealings with the Board in the past, and that this may have led to some infringements on the patients' liberty.

A third person stated that the changes were definitely a "good thing", and a clear improvement over the old system; this individual added, however, the view that most of his co-workers did not feel the same way:

> I think there were too many abuses under the old system. I don't think the new review process has made my job any harder or demanded more time. I think you'll find that I'm in the minority, though; most of the people you talk to out here seem to think Armageddon is coming.

B) Responses from Prosecutors

Of the seven prosecutors in the sample, only three had had direct experience with the Review Board. With this limitation in mind, it can be noted that two of the three echoed the comments of Forensic staff, saying they preferred an inquisitorial to an adversarial style of hearing. The third disagreed, stating that "these people (the patients) are deserving of judicial treatment, not just an administrative approach". This person went on to indicate that a number of the comments from Forensic staff were accurate depictions of the review process:

> It's true that there are a lot more lawyers at the hearings now. The hearings are going to be more time-consuming and costly, particularly if the psychiatrists appear and are cross-examined; before, they just gave in a report. The reports have to be more detailed now. A sketchy report just won't do: the Board has to be persuaded that the (hospital's) recommendations are right. I would also agree that the Board is in a formative stage, and is evolving. Procedures and rules are still being decided upon.

All three prosecutors stated that a major consequence of the new legislation was that they were more concerned about potentially dangerous individuals being released prematurely now. One stated:

> The Attorney General can apply to be a party at the hearings. We try to be present in cases where the crime was of a serious nature. One concern I have is that if one of our people isn't there at a hearing the Review Board will interpret this as meaning that the person must not be dangerous.

C) Responses from Defence Lawyers

With the defence advocates, one of the seven had considerable experience with the Review Board; three had had peripheral experience, and three had had no experience with the Review Board.

The three with peripheral experience spoke in rather general terms about the hearings, but all indicated that the hearings had offered insufficient civil rights protections in the past, and anything would be an improvement. One stated that it was a good thing that the hospital now had to justify its recommendations, that in the past too many decisions were made on the basis of "clinical hunches and intuition". Two stated that they were still sceptical that "least restrictive dispositions" would come about, particularly for more serious cases. One suggested that the Review Board still couldn't be considered an independent body since the members were all government appointees.

The lawyer with considerable Review Board experience spoke at some length on the changes, and offered a quite different perspective from the majority of the Forensic staff. Concerning the criteria governing discharge decisions:

> Before the patient was often unrepresented, and there were really no procedures in the hearings. The cabinet was motivated by political considerations. The Board itself used arbitrary, irrelevant criteria; things would be brought up in the hearing like "the patient doesn't make his bed", or "the patient is lazy". There was a very patronizing attitude on the part of the Board and the hospital staff.

Concerning the perceived eroding of the clinical relationship between psychiatrists and

patients:

> I haven't seen evidence of this happening. At least the new system forces the psychiatrist to be more honest, to tell the guy why he isn't being discharged -- he wasn't told before. This is really just a turf war. The psychiatrists are fighting because they've had to give up some of their turf.

Concerning the difference between B.C. and other provinces:

> I think Ontario's review system was always closer to the system that's now coming into B.C., so it'll be less of an adjustment for them. The legislation (Bill C-30) was modelled on the Ontario experience. I think B.C. has always had the most regressive system.

This lawyer also reiterated some of the comments made by others on the new review process: that there is now an onus to discharge patients not felt to be dangerous; that the patients now have greater access to clinical information than previously; and that the parties were still wrangling over procedural issues, but once these were addressed the review process would run more smoothly.

D) Responses from the Review Board

Finally, the Review Board official interviewed made comments similar to the defence lawyer quoted above. The official stated that "the 'good old days' (before Bill C-30) weren't that good" in that clinical staff had "too much discretion" concerning discharge decisions. The official noted that there was now a presumption against the detention of accused persons, and that absolute discharges were being recommended where it was felt that the charge was minor or the accused did not represent a "significant threat" to the public.

This person commented that the B.C. Forensic Psychiatric Services had been slow to respond to the Bill C-30 changes, and that more staff, and more staff support and training (at F.P.I.) were needed. Regarding the length of the hearings, the official suggested that:

> I think that part of the reason for the hearings taking longer now has to do with the fact that a lot of the people coming before the board are receiving conditional discharges, and the terms of the discharges are very specific, tailored to the individual case. This means that release conditions can be more complicated.

The official stated that while the Code now permitted the courts to make initial dispositions, he felt that they would decline this option and pass cases on to the Review Board: "The courts are reluctant, and perhaps nervous, about getting involved with mentally disordered offenders."

When asked about the independence of the Board, the official stated that the Board was independent (from the hospital and the provincial government), in contradiction with the comments above from one of the defence counsel.

Lastly, the official suggested, as did the defence lawyer above, that the adjustment to Bill C-30 was more difficult in B.C. than in Ontario, the latter province having had for some time, in this person's view, more of a rights-based approach to the review process. It was noted, again, that the hearings would become less arduous as procedures were established.

Issue Number Nine: Less Restrictive Dispositions for Persons Found to be Unfit or Not Criminally Responsible

Prior to Bill C-30, persons in Canada found to be unfit or NGRI were subject to an indeterminate detention. It has been argued that persons found NGRI (in particular) were often held longer than should have been necessary to restore their mental state, and thus that discharge decisions were politically (or arbitrarily) based (Harris, Rice & Cormier, 1991). The Criminal Code now states that a review board shall make dispositions for persons found unfit or NCRMD that are "the least onerous and least restrictive to the accused" (s. 672.54). Further, the Code states that persons found NCRMD who are not a "significant threat" to the safety of the public shall be discharged absolutely.

I) Interview Results

Interview subjects were asked whether the new provisions would result in more out-of-custody dispositions for persons found to be (i)unfit and (ii) NCRMD. These two categories will be discussed separately.

Will Out-of-Custody Dispositions for Unfit Persons be Common?

In brief, most of the persons interviewed for this study stated that out-of-custody dispositions for unfit persons would be infrequent.

Of the fifteen Forensic staff interviewed, two did not offer an opinion on this matter. Of the other thirteen, most were aware of at least one case (after Bill C-30) of an unfit person being given a conditional discharge to the community, but all said that this was an exception to the rule, that most unfit persons would be detained.

Several reasons were given for this. A social worker recalled a case where the Board

had recommended a conditional discharge, but defence counsel had objected, and the person had been detained; the social worker noted that "defence lawyers don't like unfit clients, and they may feel that if they're on their own in the community they (the accused) may not take the treatment they need to stay fit." An administrator suggested that conditional discharges for unfit persons were unlikely because "usually if they're unwell enough to be unfit, they're incapable of living in the community." Another administrator stated that "we (the hospital) almost always recommend detention, because if the guy goes loose in the community he'll stay unfit longer." A nurse case coordinator offered another reason:

> In most cases the court where the person was found to be unfit has not been making the initial disposition for the accused, although they have that option. They (the court) feel safer, and more comfortable handing the case over to the Review Board. The Review Board usually doesn't see the person for 45 days (the time limit stated in the Code) so that means most people will be sent out to F.P.I. for the first 45 days. At the end of that period, some are fit, and they can be returned to court after they see the Review Board. If they become fit before the 45 days is up, we'll contact the Board to recommend the person go back to court, but it usually doesn't happen that they become fit that fast.

Of the seven Crown Counsel interviewed, four did not feel familiar enough with the question on dispositions of unfit persons to offer an opinion (an indication of the infrequency with which this issue comes up). The three that commented all held the view that conditional discharges of persons found unfit would be uncommon, for some of the same reasons stated above. Two of the three were aware of at least one case of an unfit person being given a conditional discharge.

Of the defence lawyers interviewed four declined to comment, saying they lacked information or that it was "too early to tell." The other three, consistent with the responses from the prosecutors and Forensic staff, suggested that in the clear majority of cases unfit

persons would be detained at F.P.I. One of the three was aware of at least one case where an unfit person had been given a conditional discharge. One lawyer indicated that while it might not happen frequently, outpatient dispositions for unfit persons should be seriously considered, and stated that:

> People may assume that all unfit persons should be kept in F.P.I., but you have to understand that the environment inside F.P.I. is very unpleasant, and for some people their mental health may deteriorate in such a place. If you had a suicidal person, you might not want that sort of individual to remain in that kind of stressful environment. It would also be appropriate, I think, for persons whose primary problem is mental retardation to be considered for conditional discharge.[32]

Finally, the Review Board official interviewed offered a contrasting viewpoint:

> I think there will be more cases of conditionally discharged unfit persons than you might expect. You may see this in the case of people who've had a "first break" psychosis, where they may not need intensive hospital treatment. An important consideration in determining whether or not to give a conditional discharge will be: does the person have a support network in the community? Much like the conditions for granting parole.

Will Conditional and Absolute Discharges be Granted Sooner to Persons found NCRMD than was the case Prior to Bill C-30?

Prior to Bill C-30 persons found NGRI in Canada were initially held in detention,

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32. Persons whose primary problem is mental retardation are presumably less amenable to psychiatric treatment than persons whose primary problem is a psychosis such as schizophrenia; because of this, it could be argued (in some instances) that the mentally retarded do not require the controlled environment and treatment of a hospital setting. In fact, several of the Forensic staff mentioned that the only instance they could recall (in 1992) where an unfit person had been given a conditional discharge was the case of a mentally retarded man. As was discussed in Chapter Three, mentally retarded persons present a particularly difficult challenge (clinically and ethically) to the forensic psychiatric system: prior to Bill C-30 there was the risk that such persons, because of the non-treatability problem, could face lengthy detentions as unfit. With the provision of more flexible disposition options under the new legislation it may be hoped that this situation has been rectified somewhat.

then would be granted conditional discharges before being discharged absolutely. A study in Ontario (Harris, Rice & Cormier, 1991) found that the mean time in detention for insanity acquittees (for all offence categories) was six years; a B.C. study (Golding, Eaves & Kowaz, 1989) found that the mean time under supervision as NGRI (detention plus conditional discharge) was nine and one half years.

In the present study, individuals were asked if persons found NCRMD could expect to be released to the community earlier than had been the case for insanity acquittees prior to Bill C-30.

Briefly, the majority of people interviewed stated that persons found NCRMD would in most cases be released earlier to the community than they would have been under the old system.

Forensic staff were virtually unanimous in this opinion (fourteen out of fifteen). As was discussed earlier in this chapter (see "Issue Number Eight"), several Forensic staff pointed out to the author that the Review Board was apparently following the "letter of the law" (in Bill C-30) in presuming that dispositions should be "the least restrictive" and that the key discharge criterion should be whether the accused was a "significant threat to the public." A nurse case coordinator stated that:

> There is an onus now on the hospital to justify any continued detention of NCRMD cases. The attitude of the Board seems to be, "if he's not dangerous, why are you keeping him?"

This person added that absolute discharges, which were relatively infrequent under the old system, were "way up" in 1992. An administrator stated that the board was "assuming absolute discharge, unless you can prove otherwise."

In commenting on whether this policy shift was a "good" or "bad" thing, most of the Forensic staff interviewed acknowledged that under the old system a number of patients had been kept in custody needlessly. A nurse stated:

> In many cases it's probably a good thing that people get out earlier now. Before, a person would be found NGRI, and by the time he was sent back from court to F.P.I. his psychosis had been treated and he was as sane as you or I. Despite that fact, he would have to sit here for months.

On the other hand, several of the Forensic staff expressed some concerns about the new system. One individual stated that the Board was interfering too much in clinical matters, and that there was too much focus on dangerousness, and not enough on need for treatment. Several (four) other persons brought up the matter of accountability; one commented:

> The board is pushing for discharge, but they're abdicating responsibility if something goes wrong. They act with impunity. We're concerned about liability, if one of the guys they recommend for discharge goes out and does something.

Finally, a staff person stated that the assumptions made (by the Board) about conditional discharges were unrealistic:

> A lot of people are given conditional discharges now, and the board attaches all these conditions to the person's release. But it's a joke to think that once this mentally ill person is released into the community that he can be supervised in any meaningful way. There aren't the resources. I'd like to see how the person does, more gradually, at F.P.I. before releasing him right back into the city.

Of the prosecutors interviewed, three of the seven did not offer an opinion on this question because of lack of familiarity with the topic. Of the other four, all stated that persons found NCRMD would be released earlier into the community under Bill C-30. Two of these four stated that they had greater concerns about public safety as a consequence.

Of the defence lawyers interviewed, three of the seven felt they were unable to comment on the question. Of the other four, two (including the one with most experience with the Review Board) stated that persons found NCRMD would now be released earlier. The other two (who had more limited experience with this matter) were more sceptical. One said that "the new Review Board is still a conservative body." The other stated that the board would still be careful, since they would be worried about public reaction; further, this person suggested that "you might see more freedom for less serious cases, but the more serious will still face lengthy detentions."

Finally, the Review Board official interviewed stated that early releases would now be more common, both in the conditional and absolute discharge categories. Absolute discharge would be presumed where there was "no significant risk, or with minor offenses." The official suggested that, as a rough guess:

> Fifteen to twenty percent of cases coming before the Review Board will be given absolute discharges, fifteen to twenty percent will be detained, and sixty to seventy percent will get conditional discharges.

II) Archival Data

A quantitative evaluation of the effects of Bill C-30 on patient dispositions was made difficult in the present study for three reasons. First, the author did not have access to data from the Review Board, which is the body that keeps official records on dispositions of persons found unfit or NCRMD. Secondly, for some potential research questions it is likely too early to evaluate the effects of the new law; for example it was too early, at the time this report was being written, to meaningfully compare "time spent in custody" for the recent, post-Bill C-30 NCRMD cases, with the older NGRI cases (most of those found NCRMD in

the first year of the new law were still in custody at the time this study was being written up). Third, as was discussed earlier, getting data concerning outpatient cases was made difficult because the new computer codes (corresponding to new categories of outpatient assessment/disposition following Bill C-30), needed to pull information from the Forensic Services patient information system, were not in place at the time of this study.[33] This last problem was partly rectified when data, from a parallel study, was given to the author by the Executive Director of B.C. Forensic Psychiatric Services, while the present study was being written up.

Despite these limitations, there were indications from archival sources that the courts and the B.C. Review Board, after Bill C-30, were (as several interviewees suggested) applying somewhat different discharge criteria, that is, there was a presumption now that dispositions should be the "least onerous and restrictive." Two indications of this were (i) the increase in the number of absolute discharges and (ii) persons given immediate conditional discharges after being found NCRMD or unfit.

i) Absolute discharges. As was suggested in the interviews, the first year of Bill C-30 saw a dramatic increase in the number of absolute discharges[34] of persons found NGRI/NCRMD in B.C. This is shown in Figure 2, where it can be seen that in the first year

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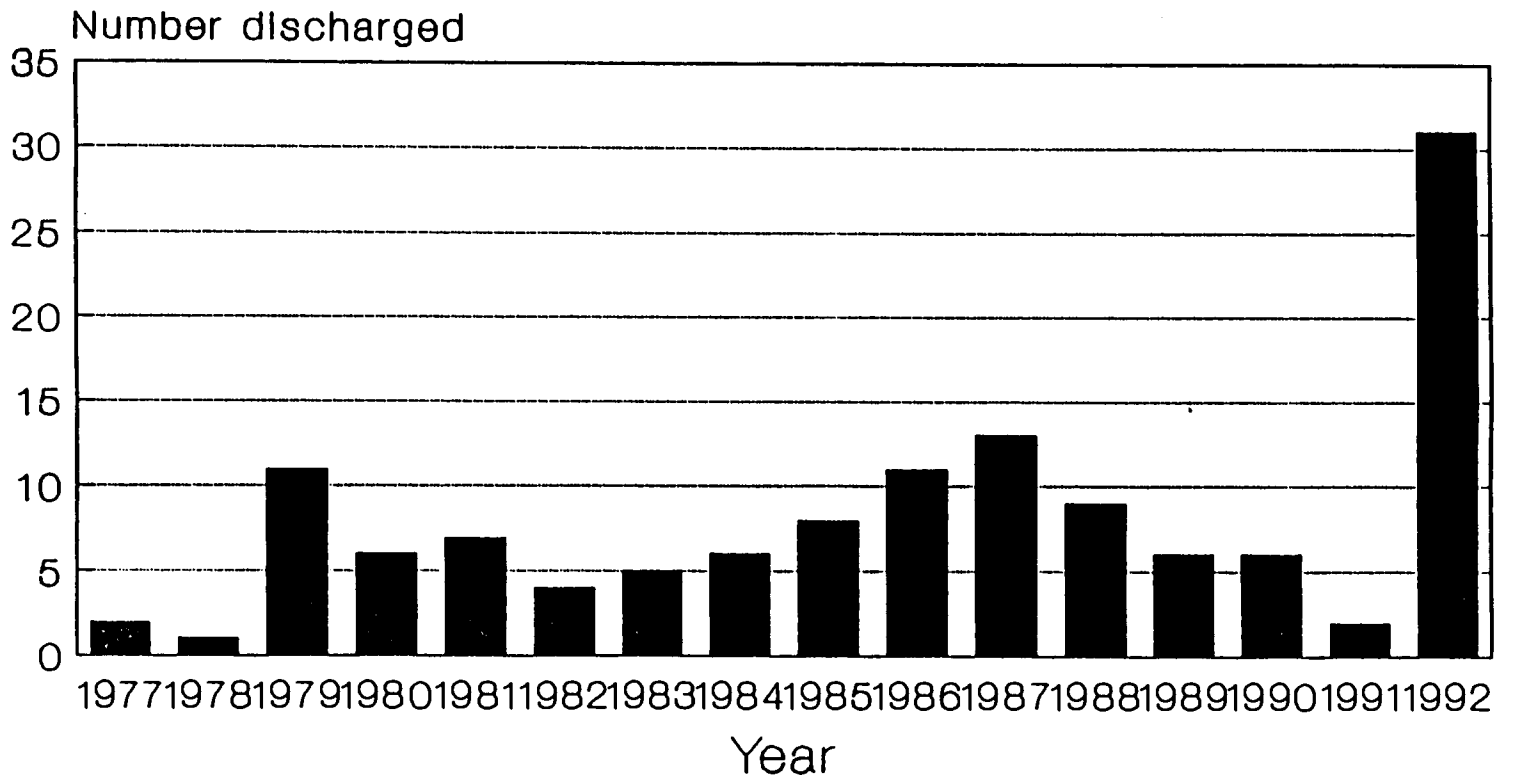
33. Cases involving the new dispositions possible after Bill C-30 were filed in the computer under a generic code that would include other types of assessments and interventions. Consequently, to get at the new categories of dispositions it was necessary to get a print-out of all cases under the generic code, then conduct a manual file search to isolate the relevant cases (i.e. it wasn't possible to get the information from a computer screen). It was only feasible in the present study to do this for the local (Vancouver) clinic.

34. Also known, in B.C., as "rescinded orders-in-council."

Fig. 2. Absolute discharges of NGRIs.



Note: 1992 figures are for Feb. 1992 - Feb. 1993

(the previous high) in 1987. (Information for this chart was obtained from a manual register of all "rescinded orders-in-council" kept by the head of Medical Records at F.P.I.)

Some explanation of this chart is necessary. The 31 persons discharged were not persons newly found NCRMD, but rather were "old" NGRI cases, with orders-in-council dating back a number of years. Thus, while one must be cautious in drawing inferences from Figure 2, it would appear that, in the first year of the new Criminal Code provisions, the Board was acting to "clear up" some outstanding cases where persons were (apparently) being held "unnecessarily" under orders-in-council. What is also notable is that six of the 31 cases were those of persons who, at the time of their absolute discharge, were inpatients; this is significant in that, to the best of the author's knowledge, absolute discharges were never given to inpatients prior to Bill C-30; rather, inpatients had to progress to conditional discharge (outpatient) status before being granted absolute discharges.

ii) Conditional discharges. Information was gathered on persons who, under the new law, were given immediate conditional discharges after a finding of unfitness or NCRMD, i.e. were discharged to an outpatient clinic without first being detained (as unfit or NCRMD) at F.P.I.

Data from the Vancouver Outpatient Clinic show that, in the first year of Bill C-30, five persons found NCRMD were given immediate conditional discharges, i.e. were sent for follow-up to the Vancouver clinic.[35] Again, the reader is reminded that prior to Bill C-30 persons found NGRI would always spend the first part of their warrant in custody at F.P.I.

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35. During the period this study was being completed, one of these five persons was sent to F.P.I., i.e. their outpatient status was apparently revoked.

It was initially assumed that only data from the Vancouver Clinic would be available; however, data made available to the author from a separate Forensic Services (1993) in-house study show that the five conditional discharges to the Vancouver Clinic in fact represent all such cases for B.C. Forensic Services outpatient clinics for the entire province.[36]

By comparison, in the first year of the new law, 15 persons were found NCRMD and initially detained at F.P.I.; this meant that of the total of those found NCRMD, one quarter were initially given out-of-custody dispositions, a not insignificant proportion.

The offences of the five persons initially given outpatient NCRMD status were as follows: break and enter; aggravated assault; sexual assault; dangerous driving resulting in death; attempted murder. Several of these charges are, arguably, serious in nature; this is notable because, historically, the length of detention faced by an insanity acquittee has largely been a function of the seriousness of the offence (Harris, Rice & Cormier, 1991). Thus, while the evidence is very preliminary, there is an indication that the courts will support initial out-of-custody dispositions even for persons charged with serious offences.

Finally, it was found in the first year of the new law that one person found unfit was given an immediate conditional discharge to the Vancouver Clinic (i.e. was not detained at F.P.I. as unfit). As with the NCRMD cases, it was confirmed from a Forensic Services study that this was the only such case for Forensic Services outpatient clinics in the entire province. The accused person was a 36 year old man charged with "causing a disturbance." Conditional discharges for unfits were never granted prior to Bill C-30, to the best of the author's

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36. The fact that these cases all wound up in the Vancouver jurisdiction may have to do with the perception that the Vancouver area has greater resources to manage such persons.

knowledge. By comparison, 30 persons found unfit in the first year of the new law served the initial part of their warrant in custody at F.P.I. Most of these persons stayed in custody until found fit, and then were returned to court. (At the time of writing of this report, several persons from this group were still being held as unfit at F.P.I., so their custody status was not yet resolved.) One of the 30 was given a conditional discharge (unfit) after spending an initial period at F.P.I., but was in fact returned to F.P.I. after breaching the conditions of his release. Thus, based on the data available, one may say that conditional discharges for unfits were a relatively uncommon occurrence in the first year of the new law.[37]

37. Regarding conditional discharges, data from the in-house Forensic Services study, referred to earlier, indicate a marked increase of total conditional discharges (NGRI/NCRMD and unfit) following Bill C-30: in the 1992-93 fiscal year there were 44 conditional discharges, vs. 26 for the 1991-92 period and 25 for the 1990-91 period. This is consistent with the suggestion, from the interview results, that conditional discharges will be a more common occurrence.

Issue Number Ten: Greater Utilization of the "Not Criminally Responsible" Defence

As noted earlier in this study, there is a perception that the defence of "not criminally responsible" will become a more attractive option with the passage of Bill C-30. Readers will recall that, under the old law, persons found to be Not Guilty by Reason of Insanity were given automatic indeterminate detentions; release criteria were somewhat vaguely stated, and persons could be held for relatively lengthy periods under Lieutenant Governors' Warrants: longer, it has been argued (Golding, Eaves Kowaz, 1989) than was needed to restore their mental state, and longer, in many cases, than persons convicted of similar offences (Harris, Rice & Cormier, 1991). (See also the interviews in this study under "Issue Number Eight.") Given the prospect of lengthy detentions, defence lawyers may have consequently felt that raising the defence for less serious matters was too risky.[38] In fact, the evidence shows that insanity acquittees have generally been charged with relatively serious offences (Rice & Harris, 1990).

I) Interview Results

Persons interviewed were asked three questions about the use of the NCRMD defence after Bill C-30, working from the premise that the consequences of being found "not criminally responsible" will be less onerous than was the case previously: (i) will the defence be raised more frequently after Bill C-30?; (ii) will the defence now be raised for lesser offences?; (iii)

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38. The relative merits of plea bargaining to a lesser offence or being found Not Guilty by Reason of Insanity are discussed by Rogers & Mitchell (1991); these authors suggest that:

> With an NGRI finding, the lawyer now loses all bargaining power for the length of the institutionalization. If the lawyer is unsuccessful in raising the defence, then it is a virtual certainty that the accused will be found guilty and may quite possibly serve a longer sentence than if the case were plea bargained in the first place (p. 149).

will the diagnostic profile of persons raising the defence change, that is, will there be greater incentive for persons to feign mental disorder to escape criminal sanctions? (The rationale for the last question is given in more detail later in this section.)

Will the Defence of Not Criminally Responsible on Account of Mental Disorder be Used more Frequently?

Interview subjects were asked: if the consequences of being found NCRMD are perceived to be less onerous, would this defence be raised more frequently than it had been in the past?

The clear majority of interview subjects answered in the affirmative to this question. All fifteen of the Forensic Services staff had the impression that NCRMD would now be raised more often. Five of the seven prosecutors felt this way; the other two did not offer an opinion. Among defence counsel four of the seven felt NCRMD would be raised more often; the other three disagreed with this suggestion. Finally, the Review Board official also believed the defence would now be more popular.

Two reasons were given for an increased use of the NCRMD defence: (i) that it was a more attractive option for the defence; (ii) that in some instances it increased the options for the prosecution, i.e. now it could be used for cases where it should have been used before -- such as where a person was truly mentally ill at the time of the offence, but because the offence was minor the NGRI defence was avoided. In addition, several prosecutors suggested that a prosecution-initiated assessment (at pre-trial) of NCRMD would be requested more often, in anticipation of defence counsel raising a full fledged NCRMD defence more often; this would be done to provide the Crown with information that could be used later if the

formal NCRMD defence was raised.

One prosecutor commented as follows:

> The NCRMD defence is now a fertile area for defence counsel. Before they tended to avoid the insanity defence. I see them bringing in mental health experts now earlier in the process than they used to. The defence is an especially good option if the illness is treatable, since that means there will be an onus to release the person early. This new legislation has increased the options for defence lawyers.

A defence lawyer stated that "before, the issue of mental illness was usually brought up at the point of sentencing, as a mitigating factor; now you'll see more full-fledged NCRMD defences". Another defence counsel suggested that there would be more pre-trial assessments where the main issue would be NCRMD, not fitness. A prosecutor suggested that:

> Before, with the NGRI defence, the Crown and the defence usually agreed that it was an NGRI case. Usually it was pretty obvious that the guy was crazy. Now, the defence will be working more on their own, raising the NCRMD defence unilaterally.[39]

The three defence counsel who disagreed with the question all cited the fact that the substantive aspects of the NCRMD defence had not changed under Bill C-30,[40] and an

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39. Why the prosecutor had this perception was not made clear, although it may have had to do with the notion (discussed in more detail later in this chapter) that there will be more "phony" NCRMD claims; that is, cases of persons feigning mental disorder to escape criminal sanctions. On the other hand, if it is true that the insanity defence has been under-utilized in the past (Ogloff, 1991) -- that is, used only for serious offences -- it would seem reasonable to suggest that the Crown would continue to cooperate with defence counsel in "legitimate" NCRMD cases; further, this cooperation would seem to be a necessity, given that successful insanity defences have, in the past, apparently required the sympathy of the Crown (Coles & Grant, 1989).

40. In fact, as noted in Chapter Three, the Supreme Court of Canada decision in Chaulk has apparently broadened the "not criminally responsible" standard (see, however, discussion on this issue in Tollefson & Starkman, 1993).

evidentiary burden still had to be met in raising the defence. They were also of the opinion that, at this point in time, it was hard to say how the Review Board would operate: one lawyer noted that: "There still may be serious consequences for persons found NCRMD; they still may end up being detained longer than if they were found guilty and sentenced."

It should be noted that many of the people who felt that NCRMD would be raised more frequently were presuming that this would be the case, but that it would take defence counsel a while to "catch on". One Forensic staff person commented that: "It may not be happening yet, but once it becomes known that most of the NCRMD cases before the Review Board are getting conditional discharges, it could really take off."

On the other hand, several persons interviewed had the impression that the increased use of NCRMD was (at the time of the interview) "already happening". Six Forensic staff, two prosecutors, two defence lawyers and the Review Board official held this opinion (it may be that Forensic staff had greater access to the relevant information). One Forensic administrator, interviewed on Oct. 7, 1992, stated that the number of NCRMDs had "tripled" compared to a year earlier.

One prosecutor stated that the NCRMD defence gave the Crown more options: it was a good thing, in other words, that the defence was now more available for "legitimate" mentally disordered persons. This person stated:

> We aren't out to "get" the accused. We don't want to see crazy people convicted. My role includes helping defence counsel. So, if counsel hasn't considered it, I might in some cases suggest the NCRMD defence to them as a course they might pursue.

At the same time, one was given the impression that several of the prosecutors interviewed were uncomfortable with the idea that NCRMD would now be raised more

frequently. This was in part because several had the perception that the defence might be abused, or used in a frivolous fashion (more on this point below). Three of the Crown interviewed suggested that, in anticipation of more NCRMD defences, it would become more common for the Crown to request a pre-trial assessment of the accused's mental state at the time of the offence, particularly for serious offenses. One commented:

> The best evidence to either support or rebut a defence of NCRMD comes from an assessment of the accused's mental state at pre-trial, right after arrest. It's easier to rebut this defence when you have information that the guy, say, seemed pretty normal at the time of his arrest. For serious offenses we'll be looking to assess the person's mental state at the time of the offence in fitness remands.

Will the NCRMD Defence now be Raised for Lesser Offences?

As noted in Chapter Three, the insanity defence in Canada has been employed primarily for more serious offences. Now that the consequences of being found NCRMD are less onerous, there is some suggestion that the defence will be raised for less serious offences (Ogloff, 1991; Packer, 1985). Interview subjects were asked if they felt that this, indeed, would be the case.

Most of the persons interviewed, particularly Forensic staff (ten of fifteen) and Crown Counsel (five of seven), stated that it seemed reasonable to suggest that the NCRMD defence would now incorporate less serious offences, although many were unsure if this was currently happening. A number of defence counsel, on the other hand, were not in agreement: four of the seven interviewed stated that they would be very reluctant to raise an NCRMD defence for a minor offence. One defence lawyer added that the NCRMD defence should be equally available, regardless of the seriousness of the offence.

While discussing this matter, several Forensic staff (four), prosecutors (two), and the Review Board official stated that the less onerous consequences of the NCRMD defence meant that it would be an attractive option as well for people charged with serious offences. As one prosecutor commented: "They certainly have nothing to lose." A Forensic staff person stated that:

> These days if you're charged with a minor offence, you're not going to get much in the way of sanctions, maybe probation or a short sentence. So, if anything, I see the NCRMD defence as more of a benefit to people charged with serious crimes.

Will the Profile of Persons raising the NCRMD Defence Change?

To qualify for an insanity defence a person has to suffer from a "disease of the mind"; further, the disorder must be of sufficient intensity as to negate his or her ability to appreciate the nature and quality of their act, or to know that it was wrong. While the phrase "disease of the mind" has been subject to various interpretations, in Canada the insanity acquittee has typically been diagnosed with a serious psychosis, commonly schizophrenia (Rice & Harris, 1990). Individuals with personality disorders (only) are much less likely to be found NGRI (Rogers & Mitchell, 1991; Verdun-Jones, 1989). The courts have ruled -- for instance in the case of Cooper v. The Queen (1980) -- that while personality disorders can qualify as a "disease of the mind", they may not be of sufficient intensity to render the person incapable of knowing the difference between right and wrong. Indeed, there is often the perception that individuals with a personality disorder are in a volitional state and thus more culpable for their actions than persons with a disorder such as schizophrenia (Appelbaum, 1993; Mitchell,

1986).[41]

In preliminary discussion with Forensic Services personnel the impression was given that the NCRMD defence, with its less onerous consequences, might "open the door" to a wider range of defendants. That is, there would now be greater incentive for persons to claim an NCRMD defence on the basis of personality disorder, or in fact to feign mental disorder to escape criminal sanctions.

To understand the perceptions of the Forensic staff it is necessary to provide some background information to put the results of the interviews in context.

In British Columbia, one of the first persons found to be NCRMD after Bill C-30 was diagnosed as suffering from a "dissociative state" at the time of that person's offence. Dissociative state is a controversial[42] condition where the accused person apparently

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41. For instance, psychologist Robert Hare (1993) states, regarding the "mad-versus-bad debate", that people with psychopathy (a personality disorder) "certainly know enough about what they are doing to be held accountable for their actions" (p. 143). Psychopathy is a condition similar, but not equivalent to, the DSMIII-R diagnosis of antisocial personality disorder, the latter being a broader category (based largely on officially recognized deviant behaviour) while the former incorporates more underlying personality traits (Hare, 1990; Hare, Hart & Harpur, 1991; Rogers & Mitchell, 1991). It should be noted that antisocial personality disorder is only one of a number of personality disorders listed in the DSMIII-R.

42. The extent of the controversy may perhaps be judged by the responses the author received in two of the interviews. One individual stated that dissociative state was a "bullshit defence" and was simply a "money maker for psychiatrists" (who testify for the defence). In another interview a psychiatrist -- who was an experienced, well respected clinician -- stated: "I can't pretend to understand the 'dissociative state' concept. I only hope I don't have a case like that." The interested reader may also refer to Freeland, Manchanda, Chiu, Sharma & Merskey's (1993) discussion of the controversy surrounding the diagnosis of multiple personality disorder (another type of dissociative disorder).

experiences a break with consciousness and may have amnesia[43] for the period of time in which the offence took place. It may be caused by "severe psychosocial stress,"[44] according to the Diagnostic and Statistical Manual of Mental Disorders (3rd ed., rev.) (American Psychiatric Association, 1987, p. 274). Dissociative state is actually a feature of several different disorders, such as psychogenic amnesia, which are classified in the DSMIII-R (1987) as dissociative disorders or hysterical neuroses.

Significantly, for the purposes of this study, it is noted in the DSMIII-R that malingering -- the possibility that the amnesia is feigned -- is a problem in diagnosing a disorder such as psychogenic amnesia. Thus, some would argue that the dissociative state defence could be exploited by "cons", persons who are simply "bad", not "mad". Psychopathy expert Robert Hare (1993), for instance, states that "it is well known that

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43. More specifically, anterograde amnesia, that is, a loss of memory for events immediately surrounding the traumatic experience and for a short time after (Paull, 1993).

44. If a dissociative state is caused by an external factor, such as a blow to the head, then the accused does not qualify for an NCRMD defence, but rather may qualify for the defence of non-insane automatism -- which leads to a complete acquittal if successful (Rogers & Mitchell, 1991; Verdun-Jones, 1989, 1993). If caused by an internal factor, i.e. a disease of the mind, then the accused may qualify for an NCRMD defence. There has been some debate as to whether "psychosocial stress", leading to dissociation, is an internal or external factor. The Supreme Court of Canada made a ruling on this issue in Rabey v. the Queen (1980): the court adopted the reasoning used in the earlier (1977) Ontario Court of Appeal decision, where Justice Martin stated (at p. 41) that dissociation resulting from "the ordinary stresses and disappointments of life" must be seen as being internally produced; he did not, however, rule out the possibility of dissociation being produced by a "psychological blow", stating that there might be some "extraordinary external events" that would produce dissociation even in an "average normal person." (Whether particular mental states constitute insane vs. non-insane automatism continues to be a contentious issue for the courts; whereas in Rabey the accused's dissociative state was ruled to be a "disease of the mind", in Parks [1992], where the accused killed his mother-in-law while sleep-walking, the Supreme Court of Canada ruled that the automatism could not be considered to be the result of any abnormal condition, and the accused was completely acquitted: see Verdun-Jones, 1993)

psychopaths often convincingly malinger -- fake mental illness -- when it is to their advantage to do so" (p. 140), and, that "memory loss, amnesia, blackouts, multiple personality and temporary insanity crop up constantly in interrogations of psychopaths" (p. 43).[45]

It is also noted in the DSMIII-R that for persons with psychogenic amnesia "the impairment is usually minimal and temporary, since rapid recovery is the rule.....recovery is complete, and recurrences are rare" (p. 274). The significance of this was pointed out in one of the interviews with a Crown prosecutor, who commented as follows:

> Suppose you have a case where a guy goes into a rage and kills his girlfriend. He claims he was in a dissociative state, and is found NCRMD. By the time he's been found NCRMD, he's fine. His condition has settled. There's nothing for anybody to treat. So, with the emphasis now on "least onerous and least restrictive" dispositions he has to be let out of custody, given a conditional discharge. Before Bill C-30 the situation was different. If someone was found NGRI because of a dissociative state it's very unlikely, in my opinion, that the cabinet would have approved any early release recommendations by the Review Board -- even if the person's condition had settled. So, there was less incentive to use the dissociative state defence under the old system.

The same prosecutor stated that it could be difficult for the Crown to rebut a defence of dissociative state, since this is a condition that (presumably) flares up and goes away quickly, and does not necessarily require defence counsel to show a prior psychiatric history, or any current, objective signs of mental disorder.

Interview subjects were asked if the diagnostic profile of persons raising the NCRMD defence would change after Bill C-30. More specifically, the discussion centred on the

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45. Whether or not clinicians are easily duped, or taken in by "cons" is another matter. Hare (1993), among others (e.g. Rosenhan, 1973), would suggest that this can happen quite readily. However, impressions gathered from interviews for the present study suggested that the clinical staff (who were, after all, forensic specialists) were well aware of the problem of malingering.

possibility of (i) there being greater incentive for persons with conditions other than chronic psychotic disorders (such as schizophrenia) to raise the defence, and (ii) there being greater incentive for persons to feign mental disorder in order to benefit from the defence.

In brief, a majority of the Forensic staff and prosecutors who responded to this question had the perception that there would be more NCRMD defences of a "questionable" nature after Bill C-30; the defence lawyers who responded disagreed with this sentiment, stating that the NCRMD defence would not be used frivolously.

The majority (twelve out of fifteen) of Forensic Services personnel held the view that the diagnostic profile of persons raising the NCRMD defence would change. Five stated that "it was already happening." The general impression given was that the system would now attract, as one psychiatrist put it, "fewer legitimate cases." In most instances the perception was that the system would attract more individuals feigning mental disorder, especially for serious crimes. Nine Forensic staff persons stated that the system would now attract more "personality disorders." An administrator noted that "there is a greater possibility now that we will be seeing psychopaths who are pretending to be crazy." (Several staff persons used the terms "psychopath" and "personality disorder" interchangeably.[46] As well, it was not always clear from the discussion whether the "personality disorders" would have a previously diagnosed personality disorder, or if individuals who would attempt to feign mental illness must by definition have some sort of personality disorder.)

Several (four) Forensic staff stated that the "dissociative state" defence would become more popular now that the consequences of being found NCRMD were less onerous. In

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46. See discussion in footnote 37, supra.

of now". Another administrator commented that "dissociative state will be the designer plea of the 1990s". Another individual noted that a dissociative state would be easier to feign than a disorder such as schizophrenia:

> With schizophrenia there is usually an established history of hospitalizations and symptomatology that indicate the person has a mental illness. In the case of the person found NCRMD (see above) due to a dissociative state, he did not have this kind of history.[47] Also, with dissociative state, amnesia is a symptom of the disorder; a lot of accused persons claim they can't remember the offence, so there may be the potential for tying in claims of amnesia with a dissociative state defence.

These four Forensic staff persons were generally sceptical as to whether a dissociative state constituted a "real" psychiatric disorder.

The view that the NCRMD defence would be abused, by people more frequently exploiting the dissociative state diagnosis, was contradicted by two forensic staff. One administrator suggested it was just a coincidence that one of the first NCRMD cases involved a dissociative state. Further, a psychologist stated:

> There has been the perception among Forensic staff that there will be more "questionable" NCRMD cases. This fear is due to the fact that we had a

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47. It should be noted that some dissociative states may, in fact, produce clearly discernible symptoms, particularly if caused by a physical blow or concussion (Verdun-Jones, 1989). For instance, one medical text notes that after a concussion, "a period of confusion is typically present. Delirium may occur. The patient may engage in simple conversation but not be able to remember it an hour or so later" (Parsons & Hart, 1984, p. 887). When a criminal action is due to the effect of a concussion, the accused may be able to plead the defence of automatism. An example of this occurred in the 1965 case of Bleta v. The Queen, where, in the course of a fight, the accused fatally stabbed another man after falling and hitting his head on the pavement. Several witnesses observed that the accused, after hitting his head, appeared to be in a "dazed condition"; the defence was able to successfully argue that Bleta was acting involuntarily, like an automaton, due to the blow on the head. The key point to be made in this example is that, because the automatism was clearly caused by an external factor, the appropriate defence was non-insane automatism, not insanity (see the reasoning outlined in footnote 44, supra).

> couple of controversial, high profile cases right after the law changed. I'm not sure that in the long run, however, these sorts of cases will predominate. You may, in the short term, see defence lawyers considering dissociative state more than they have in the past, but after a while the Crown will clamp down on the situation.

The Crown prosecutors interviewed were also asked about the changing diagnostic profile of NCRMD cases. Three of the seven were unsure about this matter and did not offer an opinion. The four that did offer an opinion gave responses similar to those from many of the Forensic staff, i.e. they held the impression that after Bill C-30 there might more defences raised of the "questionable" variety. One stated that "abuse of the system is a real concern", but added that "the evidentiary standards (of proving NCRMD) are still the same as before, so I'm not convinced that there will be successful defences that are completely frivolous."

Three of the prosecutors discussed the dissociative state phenomenon. One suggested that this diagnosis was the "in thing" right now in forensic psychiatry, and would be raised more frequently after Bill C-30. Another prosecutor, in discussing the local NCRMD case (noted above) where it had been successfully argued that the accused was in a dissociative state, stated that "a case like this wouldn't have happened under the old legislation" (because of the consequences). This person suggested that dissociative state was a "subjective, esoteric" defence, while schizophrenia, for instance, was a condition that could be more "objectively" determined. This prosecutor further commented:

> Even assuming the disorder is "real", since this is a condition that resolves itself quickly, without treatment, there will be an onus on the Review Board to give an early discharge to a person found NCRMD in these circumstances. If I were a defence lawyer, this is certainly the sort of defence I would consider.

Of the seven defence lawyers interviewed, three did not offer an opinion on the question of the diagnostic profile of NCRMD cases, citing their lack of familiarity with this matter.[48] The other four spoke in rather general terms, but offered a quite different perspective from the Forensic staff and Crown prosecutors. All four held the view that the NCRMD defence would not be used frivolously, referring to the fact that an evidentiary burden still had to be met by the defence. One also stated that: "I don't think psychopaths should get off the hook by claiming insanity."

Finally, a review board official interviewed stated that the less onerous consequences of being found NCRMD would likely attract more "malingerers" to the system. Further, while stating that the dissociative state defence was rather suspect, this individual noted that:

> The problem's not the new legislation, it's the doctors. As long as you have these psychologists and psychiatrists willing to testify about dissociative states, you have a loophole that can be exploited.

II) Archival Data

In examining the changing use of the defence of "not criminally responsible" after Bill C-30, an attempt was made to ascertain the number of persons requesting NCRMD assessment and the number of persons found NCRMD; as well, information was gathered on the criminological and diagnostic profile of persons in both of these groups. Figures from the first year of the new law were (tentatively) compared to those from preceding years.

i) Numbers raising the NCRMD defence. There are two ways to examine whether the NCRMD defence is being used more frequently. One is to look at the numbers requesting

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48. Several of the defence lawyers, for instance, were quite unfamiliar with the dissociative state diagnosis. One who had heard of it stated that it could "only be used in the defence of non-insane automatism", which, as noted earlier, is not true.

assessment for a possible NCRMD defence, and the other is to look at the numbers actually found NCRMD. These two categories will be considered separately.

In trying to determine how many persons were being assessed for criminal responsibility, this study used cases of persons seen by the B.C. Forensic Psychiatric Services for NCRMD assessment. There are a number of methodological problems, concerning this procedure, that must be discussed.

First, it is quite possible that defence counsel considering an NCRMD defence would turn elsewhere (other than B.C. Forensic Services) to have such an assessment done, i.e. to a psychiatrist or psychologist in private practice. This implies that a method that just looks at Forensic Services assessments would miss out this group of persons. On the other hand, if the number of defence requests for NCRMD assessment to private clinicians increases, one would expect to see a corresponding increase in the number of requests for Forensic Services assessments by the Crown, since the Crown generally wants an "independent" report, and usually turns to Forensic Services for this purpose. The reader may in fact recall from the interviews in this section the view that the Crown would be requesting more NCRMD assessments in anticipation of NCRMD being raised more frequently by defence counsel.

Secondly, it was not possible to reliably determine from the court referral forms who was initiating the request for NCRMD assessment. (Referrals to Forensic Services are channelled through the Crown, so that the Crown is nominally the referring source.) It would be useful, for instance, to see whether it had been the Crown or defence counsel who had initiated the request; this, however, could not be done.

A third problem concerns the interpretation of the referral forms themselves. While

the researcher is forced to take the forms at face value, there was some indication from the interviews (see discussion under "Issue Number Two") that the referring person would check off the different request boxes on the forms in an indiscriminate fashion. In the case where both "fitness" and "mental state at the time of the offence" have been requested for assessment, for instance, one cannot determine which of these issues is of primary importance; it may be that the main reason for the assessment is actually fitness, but the Crown throws in an additional NCRMD request while they're "in the neighbourhood."

An additional complication concerning the referral forms is that the forms have, as noted earlier, changed with the passage of Bill C-30, from the form shown in Appendix A to the one shown in Appendix B (although in a number of instances both forms were used). It can be seen that the wording on the two forms is somewhat different: the old form refers to "mental state at the time of the offence," while the new form refers to "whether the accused suffered from a mental disorder so as to exempt the accused from criminal responsibility by virtue of subsection 16(1) of the Criminal Code at the time the act or omission charged against the accused was committed." The new form's wording, in other words, is more specific. For the sake of this study, however, it was assumed that these two references were interpreted in the same way, i.e. that both indicated an NGRI/NCRMD assessment.

With these limitations in mind, the figures for NGRI/NCRMD assessments are shown in Table 11. The table requires some explanation. The first row shows the total of all assessments (pre-verdict and pre-sentence) where a request for NGRI/NCRMD was made (on either the old or new referral form), comparing the first year of the new law and the three

Table 11. Requests for NGRI/NCRMD Assessment, 1989 - 1992.

	1989	1990	1991	Feb. 92-Feb. 93
Total requests NCRMD or NGRI	118	124	108	139 (131 at FPI 8 at VOC)
Request NGRI/NCRMD without fitness	14	17	12	32 (27 at FPI 5 at VOC)

Note: 1989 data taken from Ogloff's (1991) study.

preceding years. The reader must bear in mind that issues in addition to NGRI/NCRMD could be requested in these cases as well. The figures for 1989, 1990 and 1991 include only inpatient (F.P.I.) assessments, since outpatient NGRI assessments were not done at that time. The figure for 1992-93 includes the numbers for F.P.I. and Vancouver Outpatient Clinic assessments. Figures for other Forensic outpatient clinics were unavailable,[49] thus the 1992-93 figure is potentially an underestimation. As can be seen from the first row, the number of assessments requested in the first year of the new law represents an increase of 31 (29%) over the previous year, although only an increase of 15 (12%) over 1990.

The data are re-analyzed in the second row of Table 11. To try to overcome the problem, discussed above, of interpreting referral forms where multiple requests were made

49. The reasons for this are discussed in the "archival data" section of Issue Number Five, earlier in this chapter.

on the same form (i.e. fitness and NGRI/NCRMD), the only forms counted in the second row were ones where a request for NGRI/NCRMD assessment was made but no request for fitness assessment was made.[50] The assumption here was that these would represent cases where the primary issue of interest was NGRI/NCRMD assessment.

The reader may wonder: why not just count the referral forms where NGRI or NCRMD was the only issue requested? The problem with doing this has to do with the nature of the older Forensic Services forms (see Appendix A). The old forms provide more options that can be checked off by the referring source (options that do not exist on the new Criminal Code forms: see Appendix B). It was found with the old forms that while there were a number of instances where "mental state at the time of the offence" was checked off and "fitness" was not, there were virtually no forms where "mental state at the time of the offence" and nothing else was checked. Thus, it was felt that using forms where "mental state at the time of the offence" was the only item checked would underestimate the NGRI assessment requests for the pre-1992 files. To reiterate, the logic here was to assume that fitness and NGRI/NCRMD were the two key legal issues, and that an absence of a request for one indicated a primary interest in the other.

Using this method, one can see from the second row of Table 11 that there was an increase of 20 "NCRMD without fitness" requests from the previous year; compared to 1990 the increase is 15, and to 1989 is 18. Thus, using this method, the increases would appear to be substantial; a longer period of analysis is needed, however, to determine whether any

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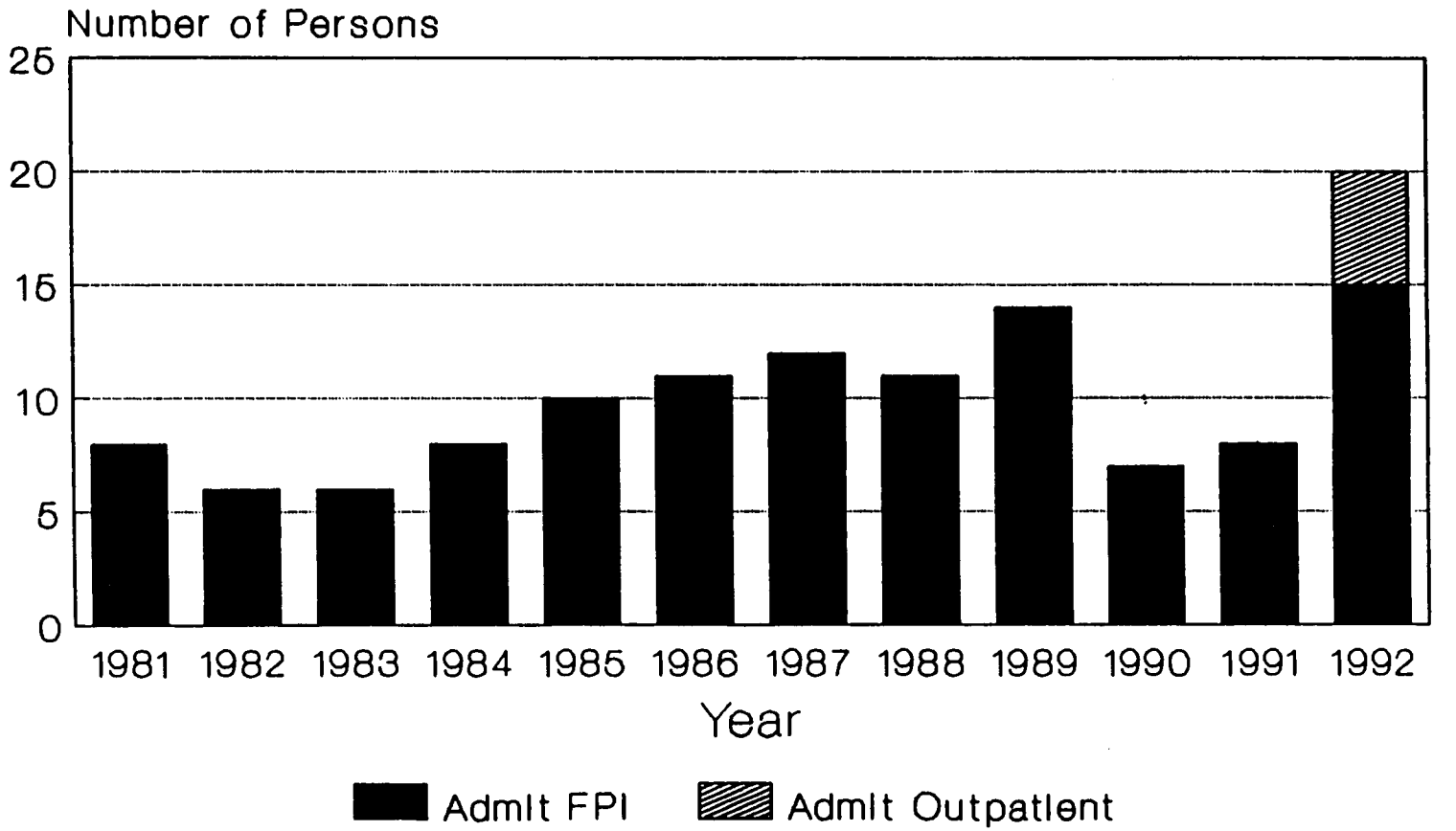
50. Where more than one type of referral form was present on the same file (i.e. an old and a new form), NCRMD and not fitness had to be the request on both forms to be scored in this category.

increases are stable, rather than transient; further, the percentage increases in this example are inflated because of the small numbers.

ii) Numbers found NCRMD. Bill C-30 provides for conditional and absolute discharges of persons found NCRMD, so determining the number found NCRMD in the first year of the new law means accounting for the number of persons (if any) given these immediate, out-of-custody dispositions. The best source for this information would be the B.C. Review Board; however, the author did not have access to Review Board records. Using Forensic Services records it was possible to discover the number of persons found NCRMD and initially admitted to F.P.I., or initially admitted to the Vancouver Outpatient Clinic. Because of the earlier discussed data retrieval problems it was not initially possible for the author to ascertain the numbers (if any) of persons given immediate conditional discharges to other Forensic Services outpatient clinics; however, information later made available to the author from a Forensic Psychiatric Services in-house study confirmed that the figures from the Vancouver Clinic represented the figures from the province as a whole, that is, there were no conditional discharges to other Forensic Services outpatient clinics. A comparison of the numbers found NCRMD in the first year of the new law with numbers from previous years is shown in Figure 3. (It should be noted that the numbers shown for the first year of the new law in Figure 3 are potentially an underestimate, since they do not include the cases, if any, of persons found NCRMD and given an immediate absolute discharge, i.e. without spending any time under a disposition as a Forensic Services inpatient or outpatient; such cases -- immediate absolute discharges of persons found NCRMD -- will presumably be uncommon. It should also be noted that the numbers pre-1992 in Figure 3 are

Fig. 3. NGRI/NCRMD cases by year



Note: 1992 figures are for Feb. 1992 - Feb. 1993

presumed to be accurate, since in this period all persons found NGRI were initially admitted to F.P.I.)

As can be seen from Figure 3, 20 persons were found NCRMD in the first year of the new law (with five being sent initially to the Vancouver Clinic, and 15 to F.P.I.). While this is an increase from previous years, it would be hard to argue that it was a substantial increase, given, for instance, that 14 were found NGRI in 1989. Since this study only looks at the first year of the new law, it is frankly impossible, at this point, to assess the effect of Bill C-30 on the numbers found NCRMD; the increase in numbers found NCRMD in the first year of the new law could be explained by other factors, unrelated to Bill C-30 (such as more mentally disordered persons in the community). In fact, there are reasons to believe the numbers found NCRMD in the first year of Bill C-30 should not be substantially higher than previous years: for one thing, some of those found NCRMD in the first year (or their counsel) would have probably first investigated the possibility of an insanity defence prior to the passage of Bill C-30, and so would have been "unaffected" by the new law; further, readers will recall that a number of the defence lawyers interviewed for this study held a "wait and see" attitude concerning the NCRMD defence, and suggested that they would still be reluctant to raise it for less serious offenses. Thus, it may take some time for an altered perception of the NCRMD defence to trickle down to the "front lines."

iii) Diagnostic profile. As noted in the interview section, some of the clinical and prosecutorial staff suggested that the diagnostic profile of persons raising the NCRMD defence might change following Bill C-30; while "traditionally" the insanity acquittee would have a chronic psychotic disorder (such as schizophrenia), now (it was suggested) more

individuals with personality and dissociative disorders would be attracted to the system.

A quantitative examination of this issue is difficult. For one thing, the reader should bear in mind that accused persons may have both a chronic psychotic (DSM-IIIR Axis I) disorder and a personality (Axis II) disorder, and it is often difficult to determine from file information which of these should be considered the primary problem. Secondly, specific diagnostic information was sometimes missing, or unclear, in the Forensic Services files.[51] Third, particular psychiatrists may have certain "pet" diagnostic categories, so that any change in diagnostic profile over time may have partly to do with the turnover of clinical personnel.[52] Fourth, for the purposes of this study, the idea that there would be an abrupt shift in diagnostic profile so soon after the passage of the new law seems implausible, notwithstanding the comment from some Forensic staff that this shift was "already happening" in the first year. With these limitations in mind, an attempt was made to get a sense of the diagnostic profile of persons found NCRMD and those being assessed for criminal responsibility.

In looking at persons found NCRMD in the first year of the new law, the files of the 16 persons admitted to F.P.I. in this period were examined.[53] Of these 16, six had a diagnosis of schizophrenia, three had "psychosis not otherwise specified," two had organic

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51. Diagnosis had to be verified by a manual file search, i.e. it was not accessible by the patient information system.

52. While diagnostic reliability in a number of categories has improved with the advent of more specific diagnostic systems -- such as the DSMIII -- it might be noted that personality disorders may be less reliably diagnosed (Andreasen & Black, 1991).

53. Fifteen of these were initially admitted to F.P.I., while one was initially admitted to the Vancouver Clinic but later transferred to F.P.I.

brain disorder, one had bipolar affective disorder, one had experienced a dissociative state, and in three cases diagnostic information was absent/unclear. One cannot draw too many conclusions from this small group of cases, except perhaps to say that the much talked about dissociative state case was not (apparently) typical of the rest of the group, with most of this number having more "conventional" psychotic disorders.

For purposes of comparison, information was gathered from previous NGRI admissions to F.P.I.; this information was made available to the author by one of the investigators[54] involved in an ongoing study of the use of the insanity defence being carried out at S.F.U. From this database it was noted that, historically, schizophrenia has been the most common primary diagnosis of insanity acquittees; of the 187 persons admitted to F.P.I. as NGRI, from the inception of the facility up to June, 1990, 134 (72.4%) have had this diagnosis (as given by the psychiatrist on the clinical file. In this same period, only one case of dissociative disorder was reported. Eighteen persons (9.6%) in this period were given primary diagnoses of personality disorder; this is notable because it shows that, while less common, insanity acquittees have, historically, been given a diagnosis of personality disorder in some cases, i.e. it is not a "modern" (post-Bill C-30) phenomenon (see also Ogloff, Schweighofer, Turnbull & Whittemore, 1992).

In addition to examining the diagnosis of persons found NCRMD, an attempt was made to gather diagnostic information on persons being assessed for criminal responsibility. As noted above, determining what constitutes a NGRI/NCRMD assessment is problematic; the decision was made to define "NGRI/NCRMD assessment" in the manner explained

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54. Dr. Bill Glackman.

earlier, corresponding to the second row of Table 11; that is, cases included for analysis were ones where assessment of mental state at the time of the offence, and not assessment of fitness, was requested on the referral forms. The diagnosis was the one given by the Forensic Services psychiatrist, in his or her report in the clinical file. The results of this analysis are shown in Table 12.

Table 12. Diagnostic Profile of Persons Being Assessed for Criminal Responsibility.

	1990	1991	Feb. 1992-Feb. 1993
1) Schizophrenia, paranoid disorder, psychotic disorder, mood disorder.	7 (41.2%)	3 (25.0%)	19 (59.4%)
2) Personality disorder, substance abuse disorder (without any other Axis I DSMIII-R disorder)	5 (29.4%)	6 (50.0%)	8 (25.0%)
3) Organic Brain disorder	2 (11.8%)	0 (0.0%)	0 (0.0%)
4) Sexual disorder	0 (0.0%)	2 (16.7%)	0 (0.0%)
5) Adjustment disorder	3 (17.6%)	0 (0.0%)	0 (0.0%)
6) No diagnosis	0 (0.0%)	1 (8.3%)	5 (15.6%)
Totals	17	12	32

In this table, diagnosis is grouped into several categories. While this grouping is somewhat arbitrary, the intent was to separate out personality and substance abuse disorders (without any other DSMIII-R Axis I disorder -- group 2 on the table), from the major mood and psychotic disorders (group 1 on the table). This is because personality and substance abuse disorders, as the basis for an insanity defence, are considered more suspect both from a clinical and legal perspective (Appelbaum, 1993; Mitchell, 1986; Verdun-Jones, 1989).

One cannot draw too many conclusions from Table 12, because of the small numbers, and because of the earlier mentioned methodological problems; nonetheless, it can be seen that the proportion of persons being assessed for criminal responsibility and having a personality or substance abuse disorder (only) was no greater in the first year of the new law than in the preceding two years, although the absolute numbers of such persons was slightly greater. On the other hand, the number of persons having major mood and psychotic disorders was greater in the first year of the new law than in the preceding two years, both as a proportion and in absolute numbers. In sum, the increase in assessments of criminal responsibility in the first year of the new law was, apparently, linked to a greater number of persons with major mood and psychotic disorders being assessed, and not so much an increase in the number of persons with personality and substance abuse disorders -- a finding consistent, if anything, with a "legitimate" use of the NCRMD defence. (One qualification is that there were more cases in the first year of the new law where diagnostic information was not present in the file; it is possible that the shorter assessment period in the first year of the new law may have made it harder for clinicians to reach a diagnosis.)

iv) Type of offence. There is some suggestion that persons may now consider the

NCRMD defence for less serious offences (Ogloff, 1991; Packer, 1985). The reader may recall, however, that the majority of the defence lawyers interviewed in this study were sceptical about this idea. Further, several persons interviewed suggested that the less onerous consequences of being found NCRMD would possibly provide a greater attraction for people charged with more serious crimes. In short, there is some question as to whether Bill C-30 will create a shift in the criminological profile of persons raising the NCRMD defence. As well, it must again be stated that any such shift would seem implausible in such a short period of time (the first year of the new law), before practitioners have had a chance to monitor the application and consequences of the new provisions.

Despite these caveats, an examination was made of the type of charges laid against persons found NCRMD and persons being assessed for NCRMD.

In looking at persons found NCRMD, cases from the first year of the new law were compared to those from the preceding three years. Cases from the first year of the new law consisted of the 15 persons initially admitted to F.P.I. and the five persons initially admitted to the Vancouver Clinic; the twenty-nine 1989 - 1991 cases were all initially admitted to F.P.I. Charges were defined as "major, serious, moderate and minor" according to the classification scheme suggested by Ogloff (1991), and reproduced in Appendix F. The results are shown in Table 13. While any conclusions must be limited by the small numbers, it is apparent that there is very little difference between the two periods, i.e. it cannot be said that persons found NCRMD in the first year of the new law were charged with less -- or more -- serious offences than persons from the previous three years. One may note, for instance, that when "major and serious" are collapsed into one category, and "moderate and minor" are collapsed

into another category, the percentages from the two periods are almost identical: 24% with lesser offenses in the earlier period, and 25% with lesser offenses post Bill C-30.

Table 13. Association Between Charge Category and Period for Persons found NGRI/NCRMD.

Nature of Charge	1989 - 1991 (n=29)	Feb. 92 - Feb. 93 (n=20)
Major	14 (48.3%)	9 (45.0%)
Serious	8 (27.6%)	6 (30.0%)
Moderate	4 (13.8%)	4 (20.0%)
Minor	3 (10.3%)	1 (5.0%)

Note: See Appendix F for definition of "nature of charge"

The results for persons assessed for an NGRI/NCRMD defence are shown in Table 14. For this analysis, the decision was made to define "NGRI/NCRMD assessment" in the manner explained earlier, corresponding to the second row of Table 11; that is, cases included for analysis were ones where assessment of mental state at the time of the offence and not fitness assessment was requested on the referral forms. The figures for the first year of the new law include the 27 inpatient (F.P.I.) assessments and the five outpatient (Vancouver Clinic) assessments. As with Table 13, offences are categorized according to Ogloff's (1991) scheme (Appendix F).

Table 14. Association Between Charge Category and Period for Persons Assessed for NGRI/NCRMD

Nature of Charge	1989 - 1991 (n=29)	Feb. 1992 - Feb. 1993 (n=32)		
		Inp't	Outp't	Total
Major	5 (17.2%)	7	1	8 (25.0%)
Serious	9 (31.0%)	6	0	6 (18.8%)
Moderate	4 (13.8%)	5	1	6 (18.8%)
Minor	11 (37.9%)	9	3	12 (37.5%)

Note: See Appendix F for definition of "nature of charge"

From inspecting the data, it would appear that there is little difference between the two time periods. Collapsing "major" and "serious" into one category, and "moderate" and "minor" into another, one can see that roughly 52% were charged with lesser crimes in the earlier period, compared to roughly 56% in the first year of the new law. As with persons found NCRMD, it can be said that persons being assessed for criminal responsibility in the first year of the new law had similar criminological profiles to persons from the previous three years.

In sum, the available archival data suggest that there was a noticeable increase in the number of persons being assessed for criminal responsibility in the first year of Bill C-30. This increase was linked with an increase in persons with major psychotic and mood disorders being referred, notwithstanding the perception, given by Forensic Services staff in interviews, that increases in referrals would be due to more "questionable" NCRMD claims.

Why there was this discrepancy between the archival data and the interview perceptions is not completely clear (although some further comment will be offered on this point in the final chapter); it may have to do with a controversial case arising -- by coincidence -- at the same time Bill C-30 was implemented, combined with a general apprehension about system changes resulting from the new law.

Chapter Six

Summary and Discussion

This chapter is divided into two sections: first, a summary of the main findings of the study -- concerning the issues and second, a more general discussion of the implications of Bill C-30, along with an attempt to place the findings in a broader theoretical context.

A) Summary of Main Findings

i) Postponing addressing the question of fitness. The new Criminal Code contains greater provision for postponing dealing with fitness at court; this is apparently a response to the criticism that (historically) many fitness remands were unnecessary, and were made in the absence of a viable prosecution case.

The defence lawyers and prosecutors questioned about this provision had had little direct experience with it, suggesting, perhaps, that it arises infrequently. The majority of those interviewed stated that this provision would have little impact on practice, and that the accused's fitness would continue to be dealt with at the earliest possible point in the proceedings. The most frequently heard comment was that postponing dealing with fitness would be "unfair to the accused." This result is similar to the one found by Eaves, Roesch, Glackman and Vallance in their 1982 study.

As an aside, it is interesting to note that the clear majority of persons remanded to F.P.I. for fitness assessments are found to be fit, based on the figures reported earlier in this study. This holds up even for the 1992 assessments, which were shorter in duration than ones made previously (hence providing less time to treat psychotic individuals). Thus, there may still be some debate about the necessity of many of the remands.

ii) Clarifying and narrowing the focus of pre-verdict assessments. The Criminal Code now explicitly states the reasons for psychiatric assessment; the Code also provides a referral form (listing these reasons) that is "narrower", with respect to what issues can be requested, than the pre-existing B.C. Forensic Services referral form. Because of these changes, the purpose of pre-verdict assessments may be clarified, and psychiatric reports, correspondingly, may be less "expansive."

A content analysis of pre-verdict psychiatric reports found that, compared to 1990, letters to the court done in the first year of the new law were somewhat less "expansive" in that they addressed fewer "extra-clinical" issues. It was not possible to determine exactly why this change occurred, although four contributing factors were suggested, three related to Bill C-30, and one not related. The "unrelated" factor was a 1990 court decision (Rogers), which limits the imposition of involuntary psychiatric treatment on persons on probation; by extension, this may limit the probation conditions psychiatrists recommend in their reports. The "related" factors were as follows: (i) the fact that pre-verdict assessments are now shorter, meaning that psychiatrists have less time to gather background and psychological testing information on the accused (see Hypothesis Number Four in Chapter Five); (ii) a general reading of the apparent intent of the new legislation (i.e. a fitness assessment means "just look at fitness"); (iii) the specific effect of the new referral forms, which now limit (to a greater extent) what can be requested for assessment.

With respect to this last point (the effect of the referral forms), it was interesting to note from the interviews that many persons -- and a majority of Forensic staff -- played down the importance of the forms per se, suggesting that "expansiveness" had to do with

psychiatric idiosyncrasy, not the dictates of a form. This view was supported by the file analysis, where it was found that issues were addressed by psychiatrists in their reports without being formally requested (a finding made by others: see Geller & Lister [1978]), and that there was considerable variability in expansiveness between psychiatrists. There was also some indication from the interviews that referring persons have, in the past, utilized the "referral check list" in an indiscriminate fashion. One implication of all this is that psycho-legal researchers may have to be careful in their "face value" interpretation of referral forms.

Finally, there was some indication that, notwithstanding the restrictions of the referral form, prosecutors may still want an expansive pre-verdict assessment; this was suggested by the practice of including old referral forms with the new ones, and the practice, in some instances, of writing additional assessment requests onto the forms. This was interesting, and somewhat disturbing, since it indicated that some prosecutors apparently felt free to circumvent procedures prescribed by the new Code provisions.

iii) Getting fitness assessments to conform to legal standards. The new Criminal Code contains standards by which an accused's fitness may be assessed; as a consequence, reports on fitness to the courts may show greater consistency.

The clear majority of persons interviewed suggested that including standards in the Code would make no difference to the way fitness assessments were written up. It was suggested that knowledge of fitness standards in the Code would not prevent individual psychiatrists from using a personal, idiosyncratic approach to fitness assessments; most of those persons interviewed stated that the B.C. Forensic Services psychiatrists already knew the standards (including ones not mentioned in the Code).

One suggestion that stems from this would be the usage of standardized fitness instruments in court reports (or, as court reports). Several persons interviewed, however, stated that fitness assessments could not be based on standardized instruments alone.

A content analysis of F.P.I. fitness reports found that, indeed, many reports were "incomplete" (in that references to particular standards were missing), and that there were inconsistencies between psychiatrists. This result is similar to the one found by Bagby (1992) in his Toronto study. Interestingly, there was an "improvement" noted in comparing 1990 and 1992 assessments (fewer missing standards in 1992), even when holding the "psychiatrist" variable constant. Given the limitations of the study, however, it is impossible to say whether the improvement was due to an awareness of the new Code or to some other factor(s).

Finally, while this provision may mean less to psychiatrists with forensic expertise, it may be fair to suggest that inclusion of standards in the Code may be useful in jurisdictions where no forensic specialists are available.

iv) Shortening the duration of fitness assessments. The Code now states that in custody fitness assessments shall normally be no more than five days in duration. With fitness assessment being a common reason for ordering pre-verdict (pre-trial or at trial) remands, this should mean that pre-verdict assessments will be shorter than the 20 - 30 day periods that were commonly used before Bill C-30, thereby minimizing the loss of liberty for pre-verdict defendants.

In looking at archival data from the first year of Bill C-30 it was found that the median length of pre-verdict assessments performed at F.P.I. dropped from 27 days (in 1991) to 15; for assessments where fitness was the only issue requested for assessment, the median

duration dropped from 28 days (in 1991) to 13.5. Clearly, there has been a substantial decrease in the length of assessments.

While assessments are shorter, it is notable that the "fitness only" assessment duration (median of 13.5 days) is still considerably higher than the five day period recommended in the Code. This was partly due to the fact that, in some cases, accused persons consented to longer remands, and that more pre-verdict assessments were extended in the first year of the new law than in preceding years. The main reason, however, for the figure of 13.5 had to do with a jurisdictional inconsistency: outlying jurisdictions in the province were continuing to order lengthy remands, even for "fitness only" cases, in the first year of the new law, while Lower Mainland courts were ordering short remands. Why this difference existed was not clear. One suggestion was that outlying courts were less familiar with the new Code provisions; if this is true, one might expect that, over time, remand lengths will come down as (hopefully) outlying courts are made more familiar with the Code.

When asked about the shorter remands, a clear majority of persons interviewed (clinical staff, defence counsel and the Crown) suggested that five days was long enough to do an assessment, provided the only issue being addressed was fitness. Most clinical staff stated that five days would not be long enough if issues other than fitness were addressed. Further, a minority of clinical staff suggested that assessments should not be limited to fitness. It was acknowledged by clinical staff that short assessments would now be less "comprehensive"; this comment received tentative confirmation in a file analysis, where it was found that considerably fewer pre-verdict assessment performed in the first year of the new law had social work and/or psychological reports on file, compared to the two preceding

years.

Finally, an hypothesis concerning a "side effect" of the new law was tested. There had been some suggestion from the interviews that a shorter fitness remand would not provide enough time to restore fitness by treatment (if necessary). In fact, it was found that rates of unfitness for fitness remands in the first year of the new law were not appreciably different from the preceding year (when remands had been longer); hence, the hypothesis was not proved. This finding, along with the fact that the majority of accused persons were found fit at the end of the remand, would seem to indicate that the fitness remands were unnecessary in many cases.

V) Performing fitness assessments out-of-custody. The practice of always holding fitness assessments in custody has received criticism; commentators have suggested that forensic psychiatric assessments can in many instances be performed on an outpatient basis (e.g. Ogloff, 1991). In the Criminal Code there is now an explicit presumption against custody for persons undergoing forensic psychiatric assessment.

Archival data from the first year of the new law indicated that outpatient assessments were relatively uncommon: only fourteen assessments of fitness and/or NCRMD were performed during this period at the Forensic Services Vancouver Outpatient Clinic (whose catchment area is Greater Vancouver). In other words, a clear majority of assessments were still being held at F.P.I. The suggestion that outpatient assessments are "uncommon" might be qualified by noting that there is apparently at least some recognition of the presumption against custody, since fitness assessments were never held out of custody in B.C. previously; further, future trends -- concerning utilization of outpatient resources -- are still unknown at

this point.

While the numbers are too small, at this point, to comment clearly on the type of case most likely to receive consideration for outpatient assessment, there was a tentative indication from the available data that persons sent for outpatient assessment were more likely to have less serious charges, and less likely to have a criminal record, than persons sent for inpatient assessments.

Persons interviewed for the study were asked if outpatient fitness assessments were, in general, feasible. A majority of clinical staff suggested that outpatient fitness assessments were in theory a good idea, but that there were practical problems that would work against them becoming a common occurrence. The legal personnel, especially the prosecutors, were for the most part sceptical as to the feasibility of outpatient assessments. The commonly raised concerns were, firstly, that if a patient was disturbed enough to be unfit, that person would likely be too disturbed to be manageable on an outpatient basis, and secondly, that there were not enough forensic outpatient resources. Regarding the last point, there was a clear consensus that outpatient fitness assessments would be uncommon in outlying areas (where there were few outpatient resources).

vi) Protecting accused persons from self-incrimination during psychiatric assessment. There has historically been a concern that statements made by an accused to a psychiatrist in a pre-trial assessment could be used against the accused at court, and could possibly lead to self-incrimination. The new Criminal Code states that such statements, with some exceptions, are "protected" from this type of usage.

It was frankly unclear from the interview results what sort of impact the "protected

statements" provision would make. Seven of the 14 legal personnel interviewed felt they were unable to offer an opinion on the matter. Of those offering an opinion, a slight majority suggested that the provision did offer greater protection against self-incrimination. On the other hand, several persons spoke about inconsistencies in the statute, i.e. instances where potentially self-incriminating statements could be admitted under one of the "exceptions." One defence lawyer suggested that the new provision may paradoxically be harmful for accused persons, since by explicitly listing the instances when statements made at assessment can be used at court, it overturned an unwritten "gentlemen's agreement" between defence counsel and the Crown in B.C. that statements made to a psychiatrist were never to be used to incriminate the accused.

vii) Increasing numbers of court-ordered assessments. One possible consequence of the new law is that more psychiatric assessments will be ordered by the courts. This may result from: (a) new categories of assessment in the Code; (b) a perception that the assessment process is less onerous; (c) more persons requesting NCRMD assessment (because the consequences of this verdict are less onerous under Bill C-30).

Archival data from the first year of the new law show that there was a small (6.8 percent) increase in F.P.I. remands (pre-verdict and pre-sentence) over the preceding year, although this increase is 12 percent when the new categories of outpatient assessment (at the Vancouver Outpatient Clinic) are included. In brief, it is difficult to say, based on figures from the first year, whether there will be a dramatic increase in court-ordered assessments.

There are several factors to be taken into account that are consistent with the view that assessments will increase because of Bill C-30. First, it is possible that the first year of the

new law was atypical; the total number of assessments includes a period in February and March of 1992 where referrals dropped, apparently because of uncertainty about the new law, before going up again. Second, there is evidence from the interviews and from archival data that requests for NCRMD assessment will increase, now that the Lieutenant Governor's Warrants have been abolished.

There are also a couple of factors suggesting that assessments will not increase. First, the new category of assessment -- assessment to determine disposition of persons found to be unfit or NCRMD -- was hardly used in the first year of the new law; this may mean that the courts are reluctant to use the discretion they now have (because of Bill C-30) to determine initial dispositions of unfit/NCRMD cases. Second, there was a suggestion from the interviews that, at least in some jurisdictions, there is now better screening of unfit persons in preliminary assessment at jail/pre-trial, thus decreasing the number of formal inpatient fitness assessments.

Finally, persons interviewed were asked if more assessments would be ordered because the assessment process was now (arguably) less onerous. There was a lot of uncertainty and no clear consensus in the responses to this question; a typical response was that "it depends on the judge."

viii) Greater procedural protections for mentally disordered accused persons in the disposition review process. Under Bill C-30, the Review Board becomes an independent tribunal. Dispositions of persons found unfit or NCRMD are to be the least onerous and least restrictive for the accused, and are to be based ultimately on a consideration of the accused's perceived dangerousness. There is in the Code explicit recognition that the accused has a

right to counsel, a (limited) right to be present at the hearing, and a (limited) right to access his or her clinical file. Further, the Board has the power to compel the attendance of witnesses, such as psychiatrists.

Persons interviewed for the study were asked how the nature and process of review hearings had changed (if at all) after Bill C-30. Quantifying responses (i.e. trying to determine majority or consensus opinions) was unfortunately made difficult in this case because the question was broadly framed and gave rise to a number of different issues.

In brief, based on the interview comments, it seems fair to say that the review process had changed substantially in B.C. because of the Bill C-30 amendments.

More specifically, Forensic Services staff suggested that: (a) the hearings were now much longer; (b) the hearings were now more legalistic and adversarial, with clinical staff having to explicitly justify release recommendations; (c) there was now greater access to clinical files, which had consequently forced a change in recording practices; (d) there was apparently an emphasis on "least restrictive disposition," based on perceived dangerousness, over "need for treatment," in making dispositions; (e) there was, at times, excessive interference by the Board in the clinical relationship between hospital staff and patient; (f) dealings with the Review Board would necessitate hiring additional Forensic Services staff; (g) on a more optimistic note, the relationship with the Board would likely improve after an initial "feeling out" period.

It should be noted that no attempt was made to ask people whether they thought the changes were "good" or "bad"; while it is fair to say that some clinical staff found the changes to be unsettling, it should also be pointed out that several clinical staff went to some

lengths to acknowledge the problems (concerning lack of procedural safeguards) with the pre-existing system.

Fewer of the legal personnel interviewed were familiar with the review process. The prosecutors expressing an opinion confirmed some of the observations made by clinical staff, and stated that the new emphasis on "least restrictive" dispositions would mean greater concern about protection of the public from dangerous mentally disordered persons.

The defence lawyers expressing an opinion held a different perspective about the review process. All stated that the old system contained too few protections for the accused person, that release decisions were too arbitrary, and that the accused did not benefit from adequate legal representation at the hearings.

ix) Less restrictive dispositions for persons found NCRMD or unfit. While persons held as unfit or NGRI under the old system were subject to automatic, indeterminate detentions, with release criteria stated vaguely in the Criminal Code, there is now, with Bill C-30, a presumption that dispositions shall be the "least onerous and least restrictive" to the accused; persons found NCRMD and not considered to be a "significant threat" are to be discharged absolutely.

A clear majority of the persons interviewed for this study suggested that individuals found NCRMD would now be discharged from custody earlier (either absolutely or with conditions) than was the case prior to Bill C-30. Several Forensic Services staff persons suggested that the Review Board was now following the "letter of the law" in presuming that dispositions should be "least onerous and least restrictive." Some of the Forensic staff added that periods of detention, in a number of instances, had been unnecessarily long prior to Bill

C-30.

On the other hand, the majority of those interviewed stated that persons found unfit would be held in custody in most cases, i.e. that conditional discharges of unfit persons would be uncommon; the suggestion was made that treating the person on an inpatient basis would, in most cases, restore fitness sooner than if the person was discharged to a less supervised setting in the community.

Archival data gave a preliminary indication that practices were changing after Bill C-30. It was discovered that the number of insanity acquittees given absolute discharges rose dramatically in the first year of the new law, to 31, from a total of 2 the previous calendar year; these 31 persons had all been found NGRI prior to Bill C-30. While caution must be used in interpreting this finding, it would seem that the Review Board was acting to "clear up" older cases where persons were, apparently, being held under warrants unnecessarily.

Another indication of changing practices concerns the fact that, in the first year of the new law, five persons found NCRMD were given immediate conditional discharges to the Vancouver Forensic Services Outpatient Clinic, something never done prior to Bill C-30. This number may be compared to the 15 found NCRMD in the same period and initially admitted to F.P.I. It is also notable that the five conditional discharges involved relatively serious charges, i.e. attempted murder, aggravated assault and sexual assault.

Finally, conditional discharges given to persons found unfit were, as the interviewees suggested, uncommon. There was one case, in the first year of the new law, of an unfit person being given an immediate conditional discharge to the Vancouver Outpatient Clinic. By comparison, in the same period, 30 persons were found unfit to stand trial and initially

detained at F.P.I. One of these 30 persons was later given a conditional discharge (as unfit) to the community.

x) Greater utilization of the "not criminally responsible" defence. Prior to Bill C-30, an insanity acquittal led to an automatic, indeterminate detention; because of this the defence was raised relatively infrequently, and usually for more serious offenses. Now that the consequences of this special defence are (apparently) less onerous, it may be utilized to a greater extent.

A majority of persons interviewed for this study, particularly Forensic Services staff, held the view that the NCRMD defence would be raised more frequently than the pre-Bill C-30 insanity defence, because of the less onerous consequences. A smaller number of persons suggested that this "was already happening" (in the first year). It was suggested that increased requests for assessment of criminal responsibility would come from both defence and prosecution. The prosecution would do this, in some cases, because of a legitimate concern about convicting persons not responsible for their actions; in other words, the NCRMD defence was now (properly) "more available." In other cases, prosecution requests for assessment would be in anticipation of increased NCRMD defenses being launched by the defence. As well, the Crown may use the assessment process to explore possible conditions that would be applied to the release of the accused person, if found NCRMD.

Archival data from Forensic Services clinical files suggested that there was in fact a noticeable increase in requests for assessment of criminal responsibility in the first year of the new law, although determining these numbers from file information is problematic.

Persons interviewed for this study were also asked if the NCRMD defence would be

used for less serious offences (than had been the case in the past). A majority of Forensic and prosecutorial staff suggested that this would be the case; on the other hand, a (slight) majority of defence lawyers disagreed, stating that they would be reluctant to raise the NCRMD defence for a lesser offence, even with the Bill C-30 provisions in place. Interestingly, a smaller number of persons suggested that the biggest incentive created by the new law was for people charged with more serious offences ("you have nothing to lose").

Archival data bearing on this issue indicated that, at least for the first year of Bill C-30, there was no effect with respect to the type of offence. In comparing cases from the first year of the new law with the preceding three years, both for persons being assessed for criminal responsibility, and for those found NGRI/NCRMD, there was found to be no significant difference in the seriousness of charges laid against the accused persons.

Finally, interview subjects were asked if the diagnostic profile of persons raising the NCRMD defence would change after Bill C-30, that is, would more people attempt to escape criminal sanctions by claiming an NCRMD defence in the absence of any serious psychiatric impairment. This question proved to be somewhat controversial, with several Forensic and prosecutorial staff speaking at length on the matter; it may be, however, that the preoccupation of these persons with this topic was due to a recent, high profile case, where a man was found "not criminally responsible" for a murder due to a "dissociative state." It was clear that several of those interviewed did not consider this case to be a "legitimate" use of the NCRMD defence.

Briefly, the majority of Forensic and prosecutorial staff interviewed suggested that there would now be more "questionable" cases, i.e. persons feigning mental disorder to

escape criminal sanctions. Two Forensic staff disagreed, stating that it was just a coincidence that one of the first NCRMD acquittals after Bill C-30 had involved a "dissociative state." As well, the majority of defence lawyers interviewed disagreed with the idea that the NCRMD defence would be used frivolously, pointing out that an evidentiary burden still had to be met by the defence, in proving that the accused was "not responsible."

Archival data did not support the idea that persons raising the NCRMD defence after Bill C-30 were less "legitimately" mentally disordered, although, of course, this study only dealt with the first year of the new law. It was found that, for persons assessed for criminal responsibility, the proportion of cases where there was no major psychotic or mood disorder was actually less in the first year of the new law than in the preceding two years; further, the proportion of cases with a diagnosis of personality disorder or substance abuse (only) was no higher in the first year than in the preceding two years. In fact, the increase in assessments of criminal responsibility in the first year of Bill C-30 was linked to greater numbers of persons with major psychotic or mood disorders being referred for assessment, a finding consistent with a legitimate use of the NCRMD defence (and also consistent with the suggestion of an under-utilization of the pre-Bill C-30 insanity defence).

B) Discussion

In this section an attempt will be made to pull together, and provide a more general discussion of, the issues examined in this study; as well, an attempt will be made to place some of the findings in a broader theoretical context. The section is organized as follows: i) a general discussion of the impact(s) of Bill C-30, both "intended" and "unintended", with reference to the regional and temporal setting of the study; ii) a comment on the perceived

"abuse" of the NCRMD defence; iii) a discussion of idiosyncrasy in the psychiatric assessment process; iv) recommendations for future research, and v) a concluding comment.

i) Assessing the impact of the new law. It may be said (with some qualifications) that the apparent intent of the Bill C-30 legislation is to provide more procedural safeguards to accused persons undergoing psychiatric assessment and detention, and to minimize unnecessary restrictions of the freedom of these persons. While it may take some time to assess the extent to which these goals have been achieved, evidence from the present study suggests that this legislation has produced a shift in the practices of the courts and the Review Board in B.C. concerning the mentally disordered offender.

First, concerning the assessment of mentally ill accused persons, there was a clear indication that the median length of inpatient assessments had been shortened in the first year of the new law. Further, there was an indication that courts are now prepared to order outpatient fitness and NCRMD assessments, a practice not previously followed, although the number of these cases was relatively small.

Second, concerning the disposition of mentally ill accused persons, the first year of the new law saw a substantial increase in the number of absolute discharges (rescindment of warrants) of "old" (pre-1992) NGRI cases, suggesting that different discharge criteria were now being applied by the Review Board; further, several of those given absolute discharges in the first year were discharged directly from inpatient status, a practice not previously followed. As well, at least five persons found NCRMD in the first year were given immediate (i.e. following initial consideration by court or Review Board) conditional discharges; again, this represents a new practice.

The assertion that Review Board practices may be changing was also supported by anecdotal information from the interviews. Forensic Services staff suggested that the nature of the review hearing had changed substantially after Bill C-30. Clinical staff were now having to be much more accountable in their dispositional recommendations at the review hearings; clinical opinions were now being questioned to a greater extent, and had to be backed up with specific references to patient behaviour and mental state, as it might bear on the release criteria stated in the Criminal Code. Interview subjects suggested that the key criterion being applied by the Board was dangerousness, and that the Board, as per the wording in the Code, was presuming that dispositions should be "least onerous and least restrictive." Clinical staff also commented on the fact that there was now (apparently) greater access to clinical information by the accused and/or their counsel. It is notable that it has apparently required a change in the statutes to produce a shift towards a "due process" model in the review process in B.C., notwithstanding the fact that earlier case decisions (see Chapter Three) have dictated that there must be "fairness" in the review process.

In sum, there is an indication that, in British Columbia, the effect of Bill C-30 will be to reduce the time spent in Forensic detention for mentally disordered accused persons, both in assessment and disposition. This conclusion must be tempered by the fact that the interpretation of the discharge criteria will be dictated by case rulings: as was noted in Chapter Three, the Orlowski (1992) decision resulted in a rather broad definition of "significant threat"-- which included "future threat" -- leaving the Review Board with considerable discretion in the restriction of absolute discharges.

Further, it is worth noting that two provisions designed (apparently) to protect the

rights of accused persons may -- based on the opinions expressed in interviews -- have an uncertain or negligible impact. The first of these concerns postponing the fitness question at court: the majority of lawyers interviewed suggested that, while the new law offers greater scope for postponing the fitness issue, in practice fitness has been, and will continue to be, dealt with at the earliest possible point in the proceedings. The second provision is the one concerning "protected statements." While, on the face of it, this provision would seem to offer greater protection to the accused person undergoing pre-trial assessment, the practical effects of the provision were not clear to half the lawyers interviewed; several lawyers in fact suggested that the provision still left open the possibility of self-incrimination.

As well, there was evidence from the present study that practitioners can, and will, attempt to circumvent the law in some instances: this assertion concerns the fact that prosecutors would attempt to "expand" the pre-trial assessment by asking for assessment of issues not prescribed in the Criminal Code.

The Bill C-30 legislation will likely have a number of secondary or "unintended" consequences, flowing from the more immediate consequences described above. One potential consequence, that deserves some comment, is that there will be an increased demand on the resources of the Forensic Psychiatric system; this may be due to (i) increased use of the NCRMD defence, (ii) an increased burden placed on outpatient resources, (iii) increased demands from the Review Board, and (iv) the use of hospital orders.

First, there is some indication that there will be an increased use of the NCRMD defence; as noted above, archival data suggest, even in the first year of the new law, an increase in requests for NCRMD assessment. In contemplating this finding, it should be

noted that an increase in NCRMD assessments will not necessarily translate into an equivalent number of successful NCRMD defences. The Crown may challenge defences that are not seen to be legitimate; Coles & Grant (1989) suggest that the sympathy of the Crown is crucial to a successful plea of non-responsibility:

> (W)e are aware of no case in which an insanity defence was able to withstand vigorous Crown cross-examination. A successful insanity defence in Canada would appear to require the sympathy of the Crown (p. 180).

On the other hand, more persons may indeed be found NCRMD if the Crown sees the NCRMD defence as a more viable option for "legitimately" mentally ill persons than it has been in the past (because of the less onerous consequences) (see Ogloff, 1991). As one prosecutor said to the author, "we don't want to convict mentally ill people." The suggestion is that the NGRI defence was, if anything, under-utilized previously.

Second, it seems likely that there will be a greater demand on Forensic outpatient resources. This will be partly due to the new option of outpatient assessments, and partly due to the (presumed) increase in the number of persons found NCRMD and given early conditional discharges. Because Forensic outpatient resources in the interior of the province are not extensive (at this point in time), this would seem to indicate that the main metropolitan clinics (Vancouver and Victoria) would bear the major brunt of any increased demand.

Third, it seems fairly certain that the demands of the review hearings will require more time and personnel from Forensic Services; this point was discussed in detail in Chapter Five. Since the key factor in making determinations about discharge (of persons found NCRMD or unfit) is dangerousness, one may presume that Forensic staff will need to

develop a more consistent protocol for dealing with this issue; this may involve combining actuarial methods of assessment and standardized instruments (such as the Psychopathy Checklist) with (the more traditionally used) clinical opinions (see Monahan, 1981, and Webster, 1992).

Fourth, Bill C-30 introduces provision for a hospital order (s. 736 of the Code), although this provision was not in effect at the time the present study was being carried out. Under this provision a court may order an offender, if acutely mentally ill at the time of sentence, to spend (up to) the first 60 days of his or her sentence in a "treatment facility." We may presume that forensic hospitals, such as F.P.I. in B.C., will be designated as the treatment facility in many instances.

The option of a hospital order has existed for some years in England and Wales, and, interestingly, there is evidence from the English experience that this provision has strained already overburdened hospital resources (Verdun-Jones, 1989b). It should be noted, however, that the hospital order in England and Wales is different from the Canadian in that the offender spends the entire duration of his or her sentence in the hospital; thus, demands on the Canadian system under this provision may not be so great, given the 60 day "cap." As well, the Canadian hospital order requires the consent of the director of the facility before the patient is admitted (s. 736.13), although a similar condition apparently exists in the English situation: see Verdun-Jones (1989b). Nonetheless, considering the large numbers of mentally disordered persons in the local court system (see Hart & Hemphill, 1989), we may anticipate that the hospital order will potentially place a considerable extra burden on the forensic psychiatric system (see also Tollefson & Starkman, 1993, p.6).

It should be noted that any increased demand on Forensic Services resources, flowing from Bill C-30, may be exacerbated by changes in the civil mental health system. As Roesch & Golding (1985) note, social systems cannot be viewed in isolation; rather, reforms in one system may produce changes in other, interconnected systems. This comment is particularly pertinent with respect to the mentally disordered offender, who sits at the junction of the criminal justice, forensic psychiatric, civil hospital and community mental health systems. Currently, in British Columbia, there is a continuing emphasis on deinstitutionalization, that is, a downsizing of the main provincial civil psychiatric facility (Riverview). This may mean that civil hospital beds will be more in demand, and more difficult to access; this, in turn, may mean that more mentally disordered persons will wind up in the criminal justice and forensic psychiatric systems, the systems "that can't say no" (Teplin, 1991). Perhaps even more significant, from the point of view of the B.C. Forensic Psychiatric Services, is the fact that a new B.C. Mental Health Act is to be brought in in the near future.[1] There was some concern expressed to the author by Forensic Services staff that the new act would place more restrictions on the imposition of involuntary treatment, possibly by adopting a model, like Ontario, where the patient's competency to make treatment decisions must be considered (McCaldon, Conacher & Clark, 1991; Verdun-Jones, 1988). If this is the case, then, with the restrictions placed on treatment of persons undergoing forensic assessment and disposition in the Criminal Code,[2] one is faced (potentially) with the situation of the psychotic forensic

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1. This act, which was reportedly to have been brought in by mid-1993, was delayed at the time the present study was being finished.

2. The reader will recall from Chapter Three that the new Code does not permit treatment of an accused person to be ordered as part of an assessment order; similarly, treatment of

patient who may be detained but not treated. How plausible this scenario is remains to be seen. One might imagine, however, the situation of an unfit person, refusing treatment, who does not meet the (new) Mental Health Act criteria for involuntary treatment[3], and whose 60 day treatment order (permitted under the Criminal Code) has expired.

The fact that there will likely be changing, and increasing, demands placed upon the forensic psychiatric system, particularly with respect to outpatient resources and review hearings, points to the need for ongoing evaluation of the effects of the new legislation.

Finally, it is stressed here that the findings of this study must be qualified by being placed in regional and temporal context. With respect to the regional context, the study concerned the workings of a particular provincial system. In B.C., the Review Board was not appointed under the Criminal Code, as is the case in other provinces; rather, an ad hoc "Order in Council Review Board" was appointed by the Solicitor General to assist him or her in giving advice to cabinet and the lieutenant governor. Thus, the B.C. Board was never a quasi-judicial body as was the case in Ontario; indeed, several persons interviewed suggested that an emphasis on procedural rights and protections in the review hearing was already in effect in Ontario prior to Bill C-30, while in B.C., it was suggested, the review process had followed the "clinical paternalism" model, giving hospital staff maximal discretion in the

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persons found NCRMD may not be ordered as part of a disposition order (although short term treatment of persons found to be unfit may be so ordered). As noted in Chapter Three, the current B.C. Mental Health Act contains a section allowing for the involuntary treatment of persons found unfit or NGRI; it is not clear how this section will be modified in the new Mental Health Act.

3. Assuming s. 25.1 of the present Act, permitting treatment of unfits and NCRMDs without the usual certification procedure, is taken out

making of dispositions. While persons interviewed in this study (particularly clinical staff) perceived a clear shift in the nature of the review process in B.C. as a result of Bill C-30, one Ontario commentator has suggested that "there will be little difference in the operation of the....Board of Review from the pre-Swain to the post-Swain phase" (O'Mara, 1991, p. 84). In short, one must be cautious in making comparisons between provinces.

Further, while differences may exist between provinces, they may also exist within provinces, between court jurisdictions. Legal personnel working at the Vancouver Provincial Court, which processes a relatively large number of mentally disordered persons (Gingell, 1991; Hart & Hemphill, 1989), may have greater knowledge of psychiatric matters and the relevant Criminal Code provisions than their colleagues in outlying areas. Lack of familiarity with the new provisions may, in part, account for the finding that outlying courts were continuing to order, to a greater extent, "long" psychiatric remands, after the provision for the "short" remands had come into effect.

With respect to temporal context, the reader is reminded that the present study focused on the first year of the new law. Thus, it may be expected that practices will conform to a greater extent with the new provisions, as practitioners, over time, become more familiar with them (and as practitioners unwilling to adapt, drop out of the system). As well, the somewhat strained relationship that existed between the Review Board and clinical staff in 1992 may become more settled as these two parties settle on procedural issues, and move out of what was described as a "reactive phase" in their relationship. Further, with respect to the timing of the study, the perception expressed by a number of clinical staff that the new provisions would attract more "phony" NCRMD claims may have been due to a coincidence,

that is, a controversial NCRMD acquittal and the implementation of the new law at about the same time. Perceptions about the use of the NCRMD defence will now be discussed in more detail.

ii) A comment on the perceived "misuse" of the NCRMD defence. As noted earlier, there was a perception held by a majority of the clinical and prosecutorial staff interviewed that the change in the law (less onerous dispositions) would attract more "questionable" NCRMD claims, that is, persons without any serious psychiatric illness trying to escape criminal sanctions. This view was not supported by the archival data, which indicate (bearing in mind methodological limitations) that persons assessed for, and found, NCRMD in the first year had a diagnostic profile similar to (with respect to serious mental disorder) cases from previous years. This apparent discrepancy, between the perceptions of interviewees and archival information, is an interesting finding, and one that deserves some further comment.

To begin with, it is possible that part of the concern had to do with apprehension about an increased work load -- apart from any opinions about the "legitimacy" of the NCRMD defence. Some of those interviewed were concerned about the prospect of being deluged with new types of cases for assessment, a finding also made by Ogloff (1991) in his survey of B.C. prosecutors.[4]

A second factor, concerning the perceived "misuse" of the NCRMD defence, may have to do with attitudes toward the insanity defence in general. Surveys have consistently uncovered a sceptical attitude on the part of the public concerning the insanity defence. In

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4. In contending with the large volume of cases at the criminal courts (Griffiths & Verdun-Jones, 1994) prosecutors may place an emphasis on "moving" and disposing of cases expeditiously (Grosman, 1969).

a review of these (mostly American) surveys, Ogloff, Schweighofer, Turnbull & Whittemore (1992, p. 205) found that a majority of persons believed that the insanity defence allowed "too many people (to) escape criminal responsibility" and that "the insanity defence is a loophole that allows too many guilty people to go free"; these authors also note that the public tends to overestimate the frequency and success rate of the insanity defence.

While these surveys concern public attitudes, one must be aware that forensic specialists, as well, may be sceptical about the use of the insanity defence. Indeed, clinicians may resent dealing with individuals who are (apparently) more "bad" than "mad", and who should -- in the clinician's view -- be more appropriately dealt with in the criminal justice system. This sort of attitude was occasionally reflected, in the present study, in comments made in the psychiatrists' reports to the courts. An example is the case of a 19 year old man, charged with assault and mischief, remanded at F.P.I. in November, 1992, for an NCRMD assessment.[5] In the report the psychiatrist stated that the accused had been "high, and impulsive" at the time of the offence, but was clearly "not delusional" and knew the "nature and quality of his act." The psychiatrist noted that "he feels he warrants an NCRMD defence because he has some blank spots in his memory" and that he was "trying to escape responsibility", adding that he was a "violent, antisocial young man" with "extreme anger control problems." The accused person in this case was given a diagnosis of antisocial personality disorder. A second example concerns the case of a 33 year old man, charged with sexual assault, and remanded in 1990 at F.P.I. for assessment of fitness and mental state at the time of the offence. The psychiatrist reported that "he uses a lot of denial, and has claims

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5. Assessment of criminal responsibility was the only item requested on the referral sheet.

of amnesia", however these claims were "not truthful." The conclusion was that "his mental illness is not related to his offending behaviour; he is simply avoiding responsibility for his actions." The accused in this case was given diagnoses of schizophrenia, paraphilia and antisocial personality disorder.

It is notable that in both of the examples, above, claims of amnesia were viewed sceptically by the psychiatrists (it will be recalled that amnesia figures prominently in the "dissociative state" condition). It is also notable, from the second example, that people may be both "mad" (have a serious mental illness such as schizophrenia) and "bad" (have criminal tendencies apart from their illness), leaving the psychiatrist to determine which feature is predominant. Individual forensic psychiatrists may in fact vary in their tendency to see "madness" vs. "badness" in the people they assess: Robitscher (1980), for instance, talks about some psychiatrists being "treatment-oriented" while others are "punishment-oriented." Some indication of different orientations, between F.P.I. psychiatrists, is reflected in the assessment content analysis performed in the present study (see Table 3 in Chapter Five), where it can be seen that some psychiatrists were more disposed to offer opinions on recidivism, sentencing and release restrictions than others.

Finally, with respect to a perceived "misuse" of the NCRMD defence, it was found in the present study that one particular, controversial, NCRMD case had figured very prominently, and was referred to by many of the persons interviewed: this was the case of a man found "not criminally responsible", around the time of the implementation of Bill C-30, for killing his girlfriend, due to being in a "dissociative state" at the time of the offence. As was detailed in Chapter Five, a number of Forensic Services staff felt that this was not

a "legitimate" NCRMD case, and some concluded that this was "just the sort of case" they would now be seeing more of. Some comment should be offered on why this case was, apparently, so influential.

To begin with, this case goes straight to the controversy over how we define "mental disorder." The courts, in fact, have defined mental disorder quite broadly (see the Supreme Court opinion in Cooper [1980]). Further, the professional manuals -- such as the D.S.M. III-R -- incorporate a very wide range of disorders. Nevertheless, it is fair to say that privately, or informally, mental health professionals make a distinction between mental disorders they consider to be "legitimate" and those that are "non-legitimate" (Bursten, 1982). In the present study, the author was given the impression that persons with personality disorders, for instance, were not considered appropriate candidates for forensic psychiatric intervention. And, as was discussed in Chapter Five, there seemed to be a broad consensus that "dissociative state" was clearly a questionable diagnosis.

There remains the question of why one case should be so influential. It is useful, in this regard, to look at the social psychology literature, in particular the research concerning the use of cognitive strategies. As Baron & Byrne (1987) note, humans use a number of mental short-cuts to "reduce information overload and make sense of human social life" (p. 78); one such short-cut is the heuristic, which these authors define as a "decision-making principle used to make inferences or draw conclusions quickly and easily" (p. 78). Some cognitive strategies, however, can lead to erroneous reasoning.

As reviewed by Baron & Byrne (1987), there are several cognitive strategies that may be relevant to understanding the influence of the "dissociative state" case, although the

discussion here is necessarily speculative. One cognitive strategy concerns the vividness effect, which, simply put, suggests that a particular case may be influential because it is more noticeable -- and, clearly, the dissociative state case was "high profile." It is also interesting to note, regarding the vividness effect, that particular case studies, perhaps because they are more colourful, "are often more persuasive than general statistics" (Baron & Byrne, 1987, p. 85). This suggests that even if statistics on the diagnostic profile of persons seen after the implementation of Bill C-30 were generally available, the single dissociative state case would still possibly have been more influential. It may also be that clinical staff were guilty of confirmation bias, that is, the tendency to "notice and recall things that support their beliefs" (Baron & Byrne, 1987, p. 87). In other words, clinical staff may have tended to notice "non-legitimate" cases more after publicity about the dissociative state case. Similarly, there is the effect of priming, that is, after a certain idea (such as the notion that there will now be greater "misuse" of the insanity defence) is planted, a person may use this idea in the interpretation of subsequent events. Finally, there is the phenomenon of theory perserverance, which refers to the finding that particular conclusions (such as the idea that the NCRMD defence will be misused) may live on even when there is no supporting evidence.

In sum, the perceived "misuse" of the NCRMD defence may have had to do with concerns about increased work load, a general scepticism about the insanity defence -- along with concerns about the apparent trend towards the "psychiatrization" of criminals (Cocozza, Melick & Steadman, 1978; Levine, 1970), and the disproportionate influence -- perhaps through the use of faulty cognitive strategies -- of a particular, high profile case.

iii) Clinical idiosyncrasy. Two of the issues examined in the present study (Numbers

Two and Three) brought up the issue of clinical idiosyncrasy, i.e. the fact that forensic psychiatrists vary with respect to what they do, and do not, address in their assessments. In the discussion of Issue Number Two there was an indication that psychiatrists could be quite expansive in their pre-verdict reports, often commenting on "extra-clinical" issues. In the discussion of Issue Number Three there was an indication that fitness was addressed in an inconsistent manner, with psychiatrists not always referring to particular fitness standards in their assessments.

To begin with, the fact that there is variability between psychiatrists is not a novel finding. Indeed, as Webster, Menzies & Jackson (1982, p. 134) suggest:

> An abundance of data has alerted us to the broad individual differences among psychiatrists in professional orientation, attention to civil liberty issues, influence by extra-psychiatric variables, and adherence to the medical model.....unconscious factors, idiosyncrasies, experience, political perspective, tolerance for deviance and sensitivity to due process have all been discussed as personal variables affecting the ultimate outcome of psychiatric decision-making.

A number of commentators have made the argument that greater consistency and reliability is needed in forensic assessments, both as an aid for the courts (Bagby, 1992), and to help protect the rights of the accused person (Menzies, Jackson & Glasberg, 1982), since "legal doctrines demand a measure of dispositional equality" (Webster, Menzies & Jackson, 1982, p. 134). The comment has also been made that the courts themselves have been unclear with respect to what they expect from forensic psychiatrists (Addington & Holley, 1987) and that standardized referral forms may help in this regard (Webster, Menzies & Jackson, 1982). The new Criminal Code in fact provides a standardized form delineating the issues to be addressed in assessment. Further, standards to help determine fitness are now included in

the Code.

The question remains: can clinical idiosyncrasy be "corrected" through attempts to standardize assessments? Before addressing this question in the context of the present study, it may be useful to look at past research on psychiatric report-writing.

Briefly, in studies examining the civil commitment process, there is evidence that physicians fill out forms, i.e. commitment certificates, in an idiosyncratic fashion, not necessarily reflecting particular statutory criteria. For instance, studies done in Ontario (Page & Yates, 1973), Manitoba (Richert & Moyes, 1983) and British Columbia (Paredes, Kanachowski, Ledwidge, Stoutenburg & Beyerstein, 1990) all found that commitment certificates, in many instances, contained irrelevant or insufficient information, and did not in fact meet the requirements of the particular mental health acts. The B.C. study by Paredes and colleagues (1990) found that 30% of the certificates could be considered "invalid" in that they did not make any reference to mental disorder, or else failed to explain why commitment was necessary (protection of self or others). Further, there is evidence that physicians may not respond to changes in civil commitment criteria: a number of studies examining the effect of "narrowing" commitment standards in Canada (Bagby, 1987; Bagby, Silverman & Ryan, 1987; Martin & Cheung, 1987) and the U.S. (see Bagby, Thompson, Dickens & Nohara, 1991, for a review) have found, interestingly, that rates of involuntary admission did not drop after the change in the law. While there are a number of different possible explanations for this (Bagby, Thompson, Dickens & Nohara, 1991; Roesch & Golding, 1985), including the possibility that some physicians are not aware of new legal standards, it seems plausible to suggest that new, narrower standards were ignored in some

instances so that patients could be hospitalized who were felt to be "in need of treatment" (Bagby & Atkinson, 1988). Indeed, Paredes et al (1990, p. 310) suggest that "the invalid certificates may have reflected a parens patriae approach to civil commitment.....physicians may have committed persons for reasons which fall short of (the "dangerousness") criteria, but which were perceived as being in the best interests of that individual."

In sum, previous research suggests that physicians may not always follow legal standards in the writing of reports, and, by extension, that these professionals enjoy a certain degree of autonomy from structural and legal constraints (Friedson, 1986; Menzies, 1989). Determining the motives of these individuals, in their discretionary activities, is difficult; it may be that they are simply operating in an expedient fashion. It also seems reasonable to suggest that physicians are motivated to "do good", with "good" being determined by their own particular ideological persuasion. Thus, using the example of civil commitment certificates, civil rights-oriented physicians may apply a narrower commitment standard, while more paternalistic physicians apply a broader standard.

The present study concerns a different type of report-writing, so comparisons with studies on the use of commitment certificates are necessarily tentative. Nevertheless, it is not surprising, given the above discussion, that a number of the persons interviewed in the present study suggested that referral forms (both the old Forensic form and the new Criminal Code form) had no impact on the way psychiatric assessments were carried out; individual psychiatrists would, it was suggested, continue to "do their own thing," regardless of the forms. Similarly, a number suggested that having fitness standards in the Code would have a negligible impact, and that fitness assessments would continue to be idiosyncratic.

Despite the interview comments, it was found that there was, in fact, some change in the content of psychiatric reports after Bill C-30, even when holding constant the effect of the individual psychiatrist. Pre-verdict assessments were somewhat less "expansive", and fitness reports were somewhat more "complete," although some inconsistencies remained. Given the methodological deficiencies of the study, however, one cannot say that the changes were "caused" by Bill C-30 alone (i.e. the new form, the inclusion of fitness standards, and/or a reading of the intent of the legislation). Other factors -- such as the length of the assessment, the Rogers decision, or greater experience in dealing with the courts -- may have had an effect. Regardless of the cause(s), there is a suggestion that recording practices can change over time, and that, while psychiatrists will retain some degree of autonomy, these practices are constrained to some extent by various structural factors.

There is a more difficult question, concerning clinical idiosyncrasy: is some idiosyncrasy in the psychiatric assessment process necessarily a "bad" thing? In addressing this question, it is important to realize that the pre-trial psychiatric remand has, historically, served a number of purposes; while the "official" purpose may be to assess fitness, there is some indication (from this and other studies) that the remand is used to divert mentally disordered offenders into the civil mental health system, or to come up with dispositional options for what are -- from the Crown's point of view -- frustrating sorts of cases (Lindsay, 1977). The Crown may feel that the mentally disordered offender should, rightly, fall within the province of the mental health system, and consequently may feel exasperated about a perceived lack of access to that system (Ogloff, 1991). One may presume that access to the mental health system will become even more of a problem as the policy of

deinstitutionalization proceeds further in B.C. In short, the Crown may feel that a more expansive psychiatric assessment -- one that does not narrowly focus on fitness -- is more useful, or in fact that a diversion into the civil system is the most appropriate course to follow. It was notable from the present study that several of the lawyers interviewed, including two defence lawyers, stressed that the pre-trial psychiatric remand did not result in any abuse of the accused person's civil rights; they stated that an expansive pre-trial assessment was not being deliberately sought as a way of building a case against the accused (although one defence lawyer disagreed with this assertion). Further, while some have commented on the unfairness of using the fitness remand as a way of by-passing the civil commitment process (Verdun-Jones, 1981), others have suggested that not seeking hospitalization in some cases would be unethical (Butler & Turner, 1981); indeed, a defence lawyer stated in the present study that diverting the case was often in the best interests of his client.

From the psychiatrist's perspective, there may be -- with respect to writing an expansive assessment -- the motivation to "do good". Depending on the persuasion of the individual doctor, this may involve going beyond the fitness assessment to a consideration of treatment options for the accused person. On the other hand, where "protection of the public" is perceived to be paramount, this may involve making comments on dangerousness and sentencing options. It is conceded that, since conceptions of "doing good" may be individually determined and ideologically driven (Robitscher, 1980), expansiveness in the forensic assessment remains a problematic issue.

In summary, the pre-trial assessment has served a variety of purposes, and, to this

end, the assessments themselves have been "expansive" in some instances. While the literature suggests that psychiatric discretion cannot be constrained completely, there is some suggestion from the present study that pre-trial forensic assessments will become more narrowly focused (on fitness, in particular) following Bill C-30. This may mean that the addressing of "extra-clinical" issues, possibly damaging to the accused's case at court, will be diminished; on the other hand, it may mean that the Courts will be presented with fewer options to consider in trying to come up with an appropriate resolution of the case.

It should also be noted that, apart from the issue of psychiatric discretion, there is still the matter of prosecutorial discretion; as noted in Chapter Five, regardless of the "narrowness" of the new Criminal Code assessment referral forms, Crown Counsel may still be able to achieve an expansive assessment by adding additional requests onto the forms, by the use of two different (the old and new) forms, or by communicating orally with the attending psychiatrist. Indeed, it is important to emphasize that the criminal justice system is composed of several sequential stages of discretionary activity (Griffiths & Verdun-Jones, 1994).

Finally, with respect to clinical idiosyncrasy, there is the issue of idiosyncrasy in the assessment of fitness itself. There was, as noted above, an indication from the archival analysis of inconsistencies among psychiatrists with respect to what criteria were addressed in these assessments. Further, there was a suggestion from a prosecutor that greater standardization -- possibly through the use of a "fitness checklist" -- was needed. This latter comment may indeed be pertinent; on the other hand, some degree of clinical judgement may still be needed in making decisions about fitness, since fitness as a construct is not easily

operationalized (Roesch & Golding, 1980) and will depend on the particulars of the case (Coles & Pos, 1985; Rogers & Mitchell, 1991). Indeed, several persons interviewed for this study stressed the importance of clinical judgement, and, further, the need for the fitness assessment to be tied into an assessment of underlying mental disorder. Because of this, one would anticipate that the psychiatric staff would be reluctant to relinquish their role to non-clinicians, notwithstanding the finding that non-clinicians, using a structured interview format, may achieve a high rate of agreement with clinical staff in decisions about fitness (Roesch & Golding, 1979). It may be that the best course is to combine the clinical interview with the use of a structured instrument (an approach that has been recommended in other types of forensic psychiatric assessments: see Webster [1992]). Another option, one that has been suggested by Roesch & Golding (1979, 1980), is to include both a clinician and a legal professional in the fitness screening interview, thus ensuring (presumably) that both clinical and legal issues are addressed. Whether this suggestion will be considered in the local context remains to be seen.

iv) Suggestions for future research. At this point a few comments concerning directions for future research will be made. These comments concern both (i) technical/methodological and (ii) substantive issues.

Regarding technical/methodological issues, future research at the B.C. Forensic Psychiatric Services will require some modifications of the patient information system, to incorporate the new patient status categories created by the new Criminal Code provisions. The reader will recall, for instance, the problems presented by coding outpatient assessments at the Vancouver Clinic under a generic computer code that could also include other types

of patient assessment or disposition. The author hastens to add that, while these modifications had not been made at the time the present study was being undertaken, such modifications may in fact be completed as this report is being read. It would also be useful to have "purpose of referral" information included on the computer for inpatient assessments, e.g.: fitness, NCRMD, etc. (vs. merely "remand: assessment"). Regardless of what codes are included in the system the corresponding data, of course, must be reliably entered: it was found in the present study, for instance, that diagnostic information was often missing from the system (and thus had to be retrieved by a manual file search).

Regarding the referral forms used by the courts, a couple of comments can be made. From a research point of view it would be useful to have more explicit information, included on the forms, identifying the party that initiated the assessment request (judge, defence or prosecutor). This would be a useful piece of information in determining, for instance, who initiates requests for NCRMD assessment. (The pre-1992 Forensic referral form -- see Appendix A -- had a section for "signature of referral source"; however, as noted earlier in this study, this section almost always referred to the Crown office, regardless of whether the Crown had in fact initiated the request. The new Criminal Code referral form -- see Appendix B -- has no such section.) Whether the courts would find it reasonable or feasible to provide such information is another matter. Further, with respect to an examination of shifting practices as a result of Bill C-30, it is too late anyway, since information concerning the pre-Bill C-30 period would have to come from the old forms.

As a more general comment on the use of the referral forms, it is suggested that caution be applied in interpreting the forms when multiple requests are made on the same

form, since it may be difficult to ascertain what the issue of primary importance to the courts is. This may be less of a problem with the new (post Bill C-30) forms, where there are fewer options for selection.

One final comment, concerning methodology, has to do with the combination of qualitative and quantitative approaches in naturalistic research. It was found in the present study that qualitative information, from the interviews, was invaluable in helping to provide a context for, and clarification of, the quantitative (file) information (see Cook & Reichardt, 1979). Further, in many instances, information concerning the decision-making practices of legal and mental health personnel is simply not accessible by archival analysis.[6] Thus, it is strongly recommended that archival researchers, where possible, "check out" their findings against other sources of information, such as interviews and questionnaires.

Moving now to substantive issues, there are a number of areas, related to Bill C-30, that warrant further investigation. Research in this area is not simply a matter of academic interest; rather, there is a real need for ongoing evaluation to help inform policy-makers, government officials and funding bodies. Indeed, this point was made, with respect to mentally disordered offenders, by both the Law Reform Commission of Canada (1976) and the Federal Department of Justice (1984). Inter-agency committees, such as (in the local area) the Committee on the Effects of Multi-Problem Persons on the Criminal Justice System, may serve a useful role in the coordination and dissemination of information. Agencies such as

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6. A different approach, in examining decision-making, is the use of experimental analogue designs (i.e. subjects being given hypothetical scenarios and asked what actions they would take); however, the gain in internal validity with this approach is accompanied by a loss in external validity (Ogloff, Schweighofer, Turnbull & Whittemore, 1992).

B.C. Forensic Psychiatric Services, and Crown Counsel, will presumably need to keep staff updated through written communications and workshops.

While the present study only looked at the first year of the new law, further study on the longer term effects of Bill C-30 is needed; in particular, the potentially increasing demand on Forensic Services resources, and changing patterns in the use of the NCRMD defence, would be areas worthy of examination. Time series designs and cross-jurisdictional comparisons would be informative. The question of treating persons who are under an assessment or disposition order may be an important area for study if, as noted above, a new Mental Health Act puts greater restrictions on involuntary treatment. It would also be useful to assess lawyers' and judges' understanding of the new Code provisions province-wide, since, as noted earlier, there is some indication that staff in outlying jurisdictions may have less familiarity with, and differentially apply, sections of the Code.[7] In particular, the matter of "protected statements" is an area that deserves further scrutiny; there is (based on the interviews conducted in this study) uncertainty about the question of privileged communications, and about the application of this new section in the Code. It would be useful to assess legal opinions on this matter, to uncover what policies (formal and informal) have been adopted by the courts, and to see if these are consistently followed between jurisdictions. With respect to the review process, further qualitative analysis (e.g. observational studies of review hearings, interviews and questionnaires directed at hearing

7. Any lack of familiarity with the mental disorder provisions will presumably be less of a problem with the passage of time. The author was aware, during the writing of this study, that prosecutors and judges, through memos and workshops, were communicating with one another about the application of the new provisions.

participants) along with quantitative analysis (using Review Board records) would likely produce some interesting insights, with respect to how decisions are made concerning the mentally disordered offender.

v) A concluding comment. Arriving at an appropriate disposition for the mentally disordered offender, one that balances treatment needs, civil rights protections, and protection of the public, will likely remain a troublesome issue; in part, this is because we can expect the "supply" of mentally disordered offenders to increase in the era of deinstitutionalization, as noted in Chapter One. Prior to Bill C-30 the Criminal Code offered little flexibility with respect to dispositions and, it seems fair to say, a number of mentally disordered accused persons were deprived of their liberty unnecessarily and arbitrarily. We may now hope, with the advent of outpatient assessments, early conditional and absolute discharges, and the hospital order, that legal and clinical personnel in the criminal justice system will be better able to "tailor" dispositions to the needs of the particular case. Whether this in fact happens will depend on resource limitations: with deinstitutionalization in the civil mental health system, an historical reluctance on the part of the community mental health system to deal with a clientele that is both mentally ill and "criminal", and the prospect of more persons using the NCRMD defence, we may anticipate a significant challenge for the outpatient and inpatient resources of the forensic psychiatric system.

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FORENSIC PSYCHIATRIC SERVICES REFERRAL FORM

A. CHECK APPROPRIATE AREA AND TELEPHONE TO ADVISE OF REFFERAL

	IN-PATIENT	OUT-PATIENT	
Mailing Address	☐ Adult Forensic Psychiatric Institute 70 Colony Farm Road Port Coquitlam, B.C. V3C 5X9 524-7716 Rapifax 660-8965	☐ Forensic Psychiatric Clinic (Van) Suite 300 – 307 West Broadway Vancouver, B.C. V5Y 1P9 660 6604 Rapifax: 660 6625	☐ Forensic Psychiatric Clinic (Vic) 946 Yeares Street Victoria, B.C. V8V 3J4 387 1465

Complete B to I - Use back of form for additional comments

B. REFERRAL SOURCE

Name	Telephone No.
Address	Position
Name of Government Service/Agency	

C. PLEASE ENCLOSE THE FOLLOWING INFORMATION ON EACH REFERRAL

1. Copy of legal document, e.g. Probation Order, Warrant of Remand	☐ Enclosed	☐ No
2. Copy or summary of police report of offence	☐ Enclosed	☐ No
3. Background information, e.g. Pre-Sentence Report, Social History	☐ Enclosed	☐ No
4. Copy of previous medical reports and court transcript	☐ Enclosed	☐ No

D. PATIENT PERSONAL DATA

Name				Aliases	
Address				Phone No.	
Sex ☐ M ☐ F	Date of Birth Y M D	Marital Status	Ethnic Origin	Social Insurance No.	Medical Plan No.

E. OFFENCE/LEGAL STATUS

☐ Supreme Court ☐ County Court ☐ Prov. Court ☐ Family Court	Location	Next Court Date
Alleged Offences		
Stage of Court Proceedings	Sections of C.C.C.	

F. REQUEST FOR PSYCHIATRIC OPINION ON

- ☐ Existence of mental illness (including certifiability)
- ☐ Fitness to stand trial
- ☐ Mental state at time of offence
- ☐ Treatment needs

REQUEST FOR

- ☐ Personality assessment
- ☐ Social assessment
- ☐ Other recommendations

G. PATIENT AVAILABILITY

☐ Yes ☐ No Escorted to F.P.I.	☐ Yes ☐ No Appointments at Clinic
Specify where in custody interview required	

H. STATEMENT GIVING REASON FOR REQUEST

I.

SIGNATURE OF REFERRAL SOURCE DATE

FOR OFFICE USE ONLY

Therapist Assigned _____ Action Taken _____ Date _____

REMARKS _____

Assessment Order

Appendix B

(Criminal Code 672.13)

Canada:
In the Provincial Court of British Columbia

xxxxxxxxxx
ourt
e of the
used

Concerning
who has been charged with the following:

Briefly list the charges

I have reasonable grounds to believe that evidence of the mental condition of the accused may be necessary to determine:

put a check mark in the appropriate box

- ☐ whether the accused is unfit to stand trial
- ☐ whether the accused suffered from a mental disorder which would exempt the accused from criminal responsibility under of the *Criminal Code* subsection 16(1) at the time of the alleged act or omission charged against the accused
- ☐ whether the accused is a dangerous mentally disordered accused under the *Criminal Code* section 672.65
- ☐ (where the accused is a female person charged with an offence arising out of the death of her newly-born child) whether her balance of the mind was disturbed at the time the alleged offence was committed
- ☐ (where a verdict of unfit to stand trial on account of mental disorder has been rendered in respect of the accused) what is the appropriate disposition to make in respect of the accused under the *Criminal Code* section 672.58
- ☐ (where a verdict of not criminally responsible on account of mental disorder has been rendered in respect of the accused) what is the appropriate disposition to make in respect of the accused under the *Criminal Code* section 672.54
- ☐ (where the accused has been convicted of the offence) whether to make an order under of the *Criminal Code* subsection 736.11(1) in respect of the accused

name the person or place responsible for doing the assessment

I order that the mental condition of the accused to be assessed by /at

specify the number of days

for a period of ☐ days. This order is to be in force for a total of ☐ days including travelling time, during which the accused is to remain:

specify where

- ☐ in custody at

list the conditions

- ☐ out of custody, on the following conditions

Dated
at

19
B.C.

signature of Justice, Judge or clerk of the court

Appendix C

FORENSIC PSYCHIATRIC SERVICES

Criminal ...e (Mental Disorder) Referral Form (u ...ompany Court Orders)

A. PATIENT PERSONAL DATA

Name	Aliases
Address	Phone No.
Gender ☐ M ☐ F | Date of Birth YY | MM | DD | Marital Status | Ethnic Origin	Personal Health Number
	Identity and Dependent Number

B. LEGAL STATUS

☐ Supreme Court ☐ Prov. Court	Location	Next Court Date
Court Reference #	Duration of Assessment Period (days)	
Alleged Offences		
Sections of C.C.C.	Stage of Court Proceeding	

C. REQUEST FOR PSYCHIATRIC ASSESSMENT OF

- ☐ Whether the accused, by reason of mental disorder, is unfit to stand trial (Sec. 672.11)
- ☐ Whether the accused suffered from a mental disorder so as to be exempt from criminal responsibility under s.16.
- ☐ (Where a verdict of unfit to stand trial has been rendered), what is the appropriate disposition to be made in respect accused pursuant to (Sec. 672.54)
- ☐ (Where a verdict of not criminally responsible has been rendered), what is the appropriate disposition to be made in respect the accused pursuant to (Sec. 672.54)
- ☐ Whether the balance of the mind of the accused was disturbed at the time of the commission of the alleged offence, accused is a female person charged with an offence arising out of the death of her newly-born child. (Sec. 672.11)
- ☐ Whether the accused is a dangerous mentally disordered accused (Sec. 672.65)

D. OTHER COURT ORDERS

- ☐ Treatment Order (672.58)
- ☐ Warrant of Committal (672.57 or 672.46)

E. PLEASE ENCLOSE THE FOLLOWING INFORMATION ON EACH REFERRAL

1. Copy of Form 48 or other Court Orders	☐ Enclosed	☐ No
2. Copy or summary of police report of offence	☐ Enclosed	☐ No
3. Background information, e.g. Pre-sentence Report, Social History	☐ Enclosed	☐ No
4. Copy of previous medical reports and court transcript	☐ Enclosed	☐ No

F. LOCATION OF REFERRAL

- ☐ Inpatient Assessment at Forensic Psychiatric Institute 70 Colony Farm Rd. Port Coquitlam B.C. V3C 5X9 Tel 524-7700
- ☐ Out-patient Assessment at Vancouver Clinic 307 West Broadway Vancouver B.C. V5Y 1P9 Tel 660-6604
- ☐ Out-patient Assessment at Victoria Clinic 946 Meares Street Victoria B.C. V8V 3J4 Tel 387-1465
- ☐ Out-patient Assessment at Kamloops Clinic #8 Tudor Village, 1315 Summit Drive Kamloops B.C. V2C 5R9 Tel 828-4661
- ☐ Out-patient Assessment at Prince George Clinic Redwood Square, 1633 Victoria St. Prince George B.C. V2L 2L4 Tel 565-7115
- ☐ Out-patient Assessment at Kelowna Clinic #202 - 1610 Bertram St. Kelowna B.C. V1Y 2G4 ...el 868-3607
- ☐ Other (please specify)

PLEASE TURN OVER

Appendix D: Interview Questions

(Note: questions 2 - 7, 9 - 16 asked of all subjects; questions 1 and 8 asked only of prosecutors and defence lawyers.)

(1) Given the provisions now in the Code, will the courts be more likely now to postpone addressing the issue of fitness?

(2) With the purpose of assessments apparently clarified and narrowed -- as reflected in the new referral forms -- will this mean that psychiatric reports to the courts will be less expansive?

(3) With fitness standards now in the Code, (i) will this aid the fitness assessment process?; (ii) will fitness assessments conducted by psychiatrists be more consistent?

(4) Is five days long enough to do an adequate assessment?

(5) Assuming there is now less time for patients to respond to treatment in fitness assessments, will this mean that more people will be found unfit at the end of the assessment?

(6) Will outpatient fitness assessments become a more common occurrence?

(7) Will outpatient assessments be more uncommon in outlying areas?

(8) Will the new provisions for "protected statements" mean that accused persons undergoing pre-trial assessment are now protected to a greater extent from self-incrimination?

(9) In general, do you think that the number of court ordered assessments will increase after Bill C-30?

(10) Is it possible that more fitness assessments will be ordered now because the assessment process is perceived to be less onerous?

(11) (i) How has the nature of the Review Board hearing changed, if at all, after Bill C-30? (ii) If there have been changes, how have they impacted on the way you do your job?

(12) Will out of custody dispositions for unfit persons be more common after Bill C-30?

(13) Will complete and absolute discharges be granted sooner to persons found NCRMD than was the case prior to Bill C-30?

(14) If the consequences of being found NCRMD are perceived to be less onerous, will this defence be raised more frequently now than it has been in the past?

(15) Will the NCRMD defence now be raised for lesser offences than was the case in the past?

(16) Will the profile of persons raising the NCRMD defence change after Bill C-30?

Appendix E

SIMON FRASER UNIVERSITY

FACULTY OF ARTS
SCHOOL OF CRIMINOLOGY

BURNABY, BRITISH COLUMBIA
CANADA V5A 1S6
Telephone: (604) 291-3213

Consent Form for Persons Being Interviewed for Bill C-30 Research Study

This form describes a research project on the effects of Bill C-30, then gives subjects an opportunity to give their informed consent to participate in an interview as part of the project.

Bill C-30 was implemented (in part) in February, 1992; it makes a number of changes to the ways mentally disordered persons charged with a crime are handled by the criminal justice system and forensic psychiatric system. My interest is in examining how the changes in the law have impacted on administrative practices. To this end, I am interviewing professionals involved with mentally disordered offenders. This study is part of a Ph.D. thesis being carried out at the School of Criminology at Simon Fraser University. The interview concerns the general impressions of subjects moreso than the details of particular cases. Any information concerning the identity of the respondent or the identity of other persons - both agency staff and clientele - will be kept in strict confidence.

The principal investigator is Simon Davis (731-3881); the supervisor of the project is Simon Verdun-Jones (291-3032). Both are affiliated with the School of Criminology at Simon Fraser University, Burnaby, B.C., V5A 1S6. Concerns about the project may be registered with either of these persons.

A copy of the questions is attached.

Having read the above, and understanding that I may withdraw from the interview at any point, I understand the nature of the project and agree to participate in the interview.

Name: _____

Address: _____

Signature: _____

Witness: _____

Date: _____

(A copy of this form will be provided to subject.)

Appendix F
Offence Categorization

Major Offences

1. First, Second-degree murder and Attempted Murder.
2. Assault causing or intended to cause serious injury, disfigurement, or mutilation.
3. Kidnapping, forcible detention/abduction, and/or hostage taking.
4. Hijacking of aircraft and/or piracy of sea vessels.
5. Treason.
6. Espionage.
7. Illegal possession and/or detonation of explosives which are likely to cause death.
8. Violent terrorist activities.

Serious Offences

1. Robbery with violence.
2. Violent sex offences (i.e. sexual assault).
3. Arson.
4. Sabotage.
5. Conspiracy to traffic or import a dangerous drug.
6. Trafficking and possession for the purpose of trafficking dangerous drugs.
7. Trafficking in illegal firearms.
8. Manslaughter.
9. Extortion.
10. Armed Robbery or Attempted Armed Robbery.
11. Prison breach.
12. Escape custody with violence.
13. Unlawful confinement.
14. Assault with a weapon.
15. Use of a firearm while committing an offence.
16. Wounding with intent.
17. Aggravated assault.
18. Attempted escape with intent.
19. M.S. Revocation.

Moderate Offences

1. Possession of dangerous drugs.
2. Trafficking, conspiracy, possession for the purpose of trafficking (soft drugs).
3. Forgery.
4. Fraud.
5. Bribery.
6. Forcible entry.
7. Break and enter/B & E and commit.
8. Criminal negligence causing death or resulting in bodily harm.
9. Non-violent sex offenses (i.e. gross indecency, indecent assault, incest).

10. Robbery (excluding armed robbery and robbery with violence).
11. Escape (non-violent).
12. Theft over $1000.00.
13. Obstruction of justice and perjury.
14. Possession of stolen property over $1000.00.
15. Possession of a weapon for a purpose dangerous to the public peace.
16. Assault causing bodily harm.
17. Drinking and driving.
18. Refusing a breathalyzer.
19. Possession of housebreaking tools.
20. Theft of a motor vehicle.
21. Dangerous driving.
22. Assaulting a peace officer.
23. Parole revocation.
24. Pointing a firearm.

Minor Offenses

1. Possession of stolen property under $1000.00.
2. Common assault.
3. Possession of "soft" drugs.
4. Theft under $1000.00.
5. Public mischief.
6. Criminal negligence not resulting in bodily harm.
7. Possession of a restricted or prohibited weapon.
8. Possession of forged currency, passports, cheques.
9. Unlawfully-at-large.
10. Failure to appear.
11. Breach of probation.
12. Vandalism/Damage property/Wilful damage.
13. False pretenses.
14. Breach MVA.
15. Theft of telecommunications service (abusing phone privileges).
16. Utter a threat/Intimidation.
17. Conspiracy.
18. Failure to comply with recognizance.
19. Obstructing a peace officer.
20. Failure to stop at an accident.
21. Remand.
22. Causing a disturbance.
23. Unlawfully in a dwelling.
24. Trespassing on property.
25. Harassing phone calls.
26. Resisting arrest.
27. Vagrancy.
28. Setting of false fire alarms.

Appendix G

Province of British Columbia
Ministry of Health and
Ministry Responsible for Seniors

FPSC

Dr. D. Eaves, Executive Director
Forensic Psychiatric Services

Forensic Psychiatric Services Commission
3405 Willingdon Ave. Burnaby B.C.
V5G 3H4

Phone: (604) 660-5577
Fax: (604) 660-5766

July 2, 1992

Ms. Linda Westfal
Supervisor
Medical Records
Forensic Psychiatric Institute

This is to confirm that at PAC we approved Simon Davis' research proposal. Could you please make files available to him as needed.

Dr. Derek Eaves
Executive Director
Forensic Psychiatric Services

c.c. Ms. B. Green
Ms. M. Bailey

Together
We Care

Appendix H

SIMON FRASER UNIVERSITY

VICE-PRESIDENT, RESEARCH

BURNABY, BRITISH COLUMBIA
CANADA V5A 1S6
Telephone: (604) 291-4152
FAX: (604) 291-4860

April 27, 1992

Mr. Simon Davis
School of Criminology
Faculty of Arts
Simon Fraser University
Burnaby, B.C.

Dear Mr. Davis:

Re: "Exploring the impact of Bill C-30 on the handling of mentally disordered offenders"

This is to advise that the above referenced application has been approved on behalf of the University Ethics Review Committee.

Sincerely,

William Leiss, Chair
University Ethics Review
Committee

cc. S. Verdun-Jones
M. Jackson