FITNESS TO STAND TRIAL AND MENTALLY CHALLENGED DEFENDANTS: EVALUATION OF THE FORENSIC PROCESS AND THE CRIMINAL CODE OF CANADA

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Fitness to Stand Trial and Mentally Challenged Defendants: Evaluation of the Forensic Process and the Criminal Code of Canada

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Abstract

The goals of this exploratory research were to identify the relationship between fitness to stand trial and mental retardation among criminal defendants, and to evaluate the forensic processing of mentally challenged (MC) accused persons referred for fitness assessments. Over three one-year study periods, 52 files were reviewed, comprised of files of 30 non-mentally challenged subjects, 8 MC subjects, and 14 dual-diagnosed subjects (i.e., persons diagnosed with an Axis I clinical syndrome as well as mental retardation) referred for court-ordered assessments at the Forensic Psychiatric Institute in British Columbia. A coding manual was used to code information on sociodemographic characteristics, psychiatric history, criminal history, and psychiatric assessment. MC patients were younger than other patients at the time of admission, had longer periods of institutionalization in mental health facilities, and exhibited different criminal behaviour as determined by past criminal convictions and current charges.

Concerns were raised about diagnostic practices and the lack of standardized evaluations for fitness to stand trial. It was suggested, first, that symptoms of mental retardation, including borderline intellectual functioning, should be investigated, and second, that standardized psycholegal measures specifically designed for fitness evaluations of defendants with mental retardation should be utilized. The CAST-MR, for example, involves increased reliance on multiple-choice questions and vocabulary and syntax appropriate for MC adults whose fitness to stand trial is questioned.

Utilization of standardized procedures has been advocated for some time. While the Criminal Code of Canada states the criteria for a finding of unfitness (i.e., on account of mental disorder, the accused is unable to understand the nature or object of the proceedings, to understand the possible consequences of the proceedings, or to communicate with counsel), the emphasis remains on mental disorder (i.e., disease of the mind), which is quite different from mental retardation.

Standardized assessments and established procedures would assist in the forensic processing of defendants with mental retardation and would also restrict the flow of extraneous information or inappropriate recommendations from the clinic to the court, such as offering non-solicited opinions concerning long-term treatment plans beyond the competence issue.

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Chapter One

Introduction

In the past, mentally challenged (MC) individuals who committed criminal offences were considered "stupid and bad" (Brown & Courtless, 1968:1169). In 1690, for example, John Locke explained the difference between mental disorder and mental handicap: The insane (mentally disordered) had the power to reason but reasoned incorrectly, whereas the idiotic (mentally challenged) lacked the power to reason at all. The insane suffered a temporary loss of sense and the idiotic lacked a mind or sense at all (National Institute on Mental Retardation (NIMR), 1981:87). Ruedrich and Menolascino (1984:49) state that, by the early 1900's, people came to support four distinct conclusions:

> (1) [t]here were more retarded persons in our society than people realized; (2) the mentally retarded accounted for virtually all of the current social ills; (3) heredity was the major cause of mental retardation; and (4) because the "decadent" retarded appeared to reproduce faster than nonretarded citizens, society would soon be destroyed unless dramatic measures were taken.

There was also much support during the first three decades of this century for the belief that "virtually every mentally retarded individual was a potential juvenile delinquent, and that most criminals had overt manifestations of mental retardation" (Ruedrich & Menolascino, 1984:60). Consequently, when MC individuals committed criminal acts, their behaviour was attributed to their mental defectiveness, but when non-impaired individuals committed criminal acts, their behaviour was not attributed to anything "special" (Clinard & Meier, 1975).

There is now a growing recognition that mentally challenged individuals who act illegally are doubly disadvantaged. Brown and Courtless (1968) have argued first

that, owing to their mental condition, MC persons are disadvantaged because of difficulty adapting to the requirements of life in society. Second, when MC individuals commit illegal acts, they are disadvantaged because of rejection by social agencies such as prisons and mental hospitals:

> [t]he retarded offender is rejected on all sides: by the supporters of mental retardation programs, who feel he is primarily criminal and only secondarily retarded, and by the correctional field, who place the retarded offender as low man on the totem pole of those who might benefit from treatment and rehabilitation programs (Brown & Courtless, 1968:1169).

Despite the widespread belief that MC individuals possessed a natural proclivity for criminality, their fitness to stand trial has received much less attention. McGarry (1972) asserted that the issue of fitness to stand trial was raised too frequently for mentally disordered accused and too infrequently for MC accused. Furthermore, the fitness doctrine has been the focus of much discussion primarily in the context of mentally disordered individuals, while the applicability of the doctrine to MC persons and the differences between mental disorder and mental retardation are often ignored (Ellis & Luckasson, 1985). The failure of courts to connect the issues of fitness to stand trial and mental retardation has been blamed on "a judicial tendency to view competency questions in a vacuum, independent of the symptomology of mental illness and without any mechanism for integrating medical information concerning retardation into legal decision making" (Mickenberg, 1981:366). As a result, MC accused are often not referred for examination to determine fitness to stand trial.

It is acknowledged that "a defendant may be psychotic, mentally retarded, or deaf and mute, yet still be competent to stand trial" (Grisso, 1988:9), and that the presence of mental retardation does not automatically result in a verdict of unfit to stand trial (Bonnie, 1990; Paull, 1993). What is important is how the mental

impairment affects the person's ability to appreciate her or his legal predicament and work with her or his lawyer (Bonnie, 1993; Nicholson & Kugler; 1991). The issue of fitness to stand trial is crucial for MC accused because of the unlikelihood that individuals functioning in the moderate range of mental retardation or lower will achieve "restoration" of fitness (Bonnie, 1990; Pierrel, 1985). The combination of deficits in intellect and adaptive behaviour, and the lack of a "cure" for mental retardation inhibits responsiveness to treatment or training that would increase the possibility of a finding of fitness to stand trial. Indeed, Pierrel (1985) found that the best overall predictor of competency for defendants with mental retardation was adaptive behaviour, and that training was unsuccessful for defendants with moderate mental retardation.

Statement of Problem

The experience of MC individuals in the Canadian criminal justice system has received minimal attention in Canadian literature. For example, in a recent Canadian report on MC persons incarcerated for criminal offences, Canadian literature accounted for less than 20% of all references (Endicott, 1991). Similarly, there is a noticeable lack of literature addressing how the doctrine of fitness applies to MC accused even though this issue has been described as "the most significant mental health inquiry pursued in the system of criminal law" (Stone, 1975:200). Savage (1981) reported that persons with low intellectual functioning have been seriously disadvantaged with respect to fitness to stand trial because the Criminal Code of Canada (the Code) emphasizes mental disorder as the basis for a finding of unfitness to stand trial. This emphasis on mental disorder is explicit in Section 2 of the Code--a finding of unfitness to stand trial is "on account of mental disorder."

Because mental disorder is now defined in the Code as a "disease of the mind", it is arguable that unfitness to stand trial is precluded as an option for MC accused because "mental deficiency, or mental retardation, is usually a defect rather than a disease, in that it represents a person's failure to develop an adequate level of intellectual incapacity from birth or from an early age" (Curran & Shapiro, 1970:140). The Vancouver, British Columbia, Crown Counsel Office contends, however, that mental handicap may amount to a mental disorder if it otherwise satisfies the requirements of Section 2 of the Code. Such a situation has not yet been encountered even though the relevant section has been in force for over a year. (M. Armstrong, personal communication, April 6, 1993).

There is an urgent need for research on the situation of MC individuals involved in the Canadian criminal justice system (Endicott, 1991). The relationship between fitness to stand trial and MC accused is also gaining recognition as an important issue in Canada. In November, 1992, the British Columbia Ministries of the Attorney General, Health, Social Services and the Ministry Responsible for Seniors received a report outlining protocols for the coordination of governmental services for mentally disordered and "mentally handicapped" persons involved in the criminal justice system. The report begins with the acknowledgment that "[there] are a substantial number of persons with mental disorder or mental handicap who move back and forth between the criminal justice system and mental health system" (Committee on the Effects of Deinsitutionalization on the Criminal Justice System, 1992:1). This acknowledgment suggests that the issue of MC offenders is a significant problem in Canada. This is the basis for the following discussion.

Research Objectives

This research examined the relationship between fitness to stand trial and MC accused persons from two perspectives. First, this study sought to determine whether MC accused individuals referred for forensic psychiatric assessment of fitness to stand trial are processed differently from non-MC and dual-diagnosed persons.[1] The second objective was to determine whether the amendments to the 1992 Code have had an impact on the processing of MC accused persons remanded to a forensic psychiatric institution for fitness assessments. Currently, Section 672.14 of the Code asserts that assessment orders to determine whether the accused is unfit to stand trial are in force for only five days, unless the accused and prosecutor agree to a longer period not exceeding thirty days. The court may extend the order to a period of sixty days under "compelling circumstances."

Only since February, 1992 has the Code expressly delineated the criteria for a finding of unfitness to stand trial or provided a definition of mental disorder. Generally a verdict of unfitness to stand trial is rendered when the accused is unable, on account of mental disorder (i.e., disease of the mind), to understand the nature, object, or personal import of the criminal proceedings, or communicate with counsel. There is no statutory definition of disease of the mind, although a considerable body of case law has developed in relation to this issue (e.g., Rabey v. The Queen, (1980); Regina v. Parks, (1990)).

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1 Non-MC persons are those who are not diagnosed as mentally retarded. Dual-diagnosed persons are those who are diagnosed as both mentally disordered and mentally retarded. This term is not to be confused with the term "dual status offender" which is defined in the Code (section 672.1) as "an offender who is subject to a sentence of imprisonment in respect of one offence and a custodial disposition in respect of another offence."

A review of legal and medical files of persons remanded to the Forensic Psychiatric Institute (F.P.I.) in Port Coquitlam, British Columbia was the basis for gaining an understanding of the applicability of the doctrine of fitness to stand trial for MC accused individuals. This research spans three time periods: 1985-1986, 1990-1991, and 1992-1993.

This research represents a response to the claim by Brown and Courtless (1968) that:

> the significance of the problem [of MC individuals in the criminal justice system] far outweighs the small number of people involved, both from the potential for acquiring new scientific knowledge and from the dramatic need to confront a problem of major social and humanitarian importance (p. 1164).

Also, because of the paucity of literature which reviews the applicability of the fitness doctrine to MC persons, the descriptive portion of this study will help to fill a gap in the research covering the field of mental retardation. Seltzer (1991) stressed that research that improves understanding of the phenomenon of mental retardation itself is necessary. This study also constitutes a reply to this need.

The following discussion of the relationship between the fitness issue and MC accused persons begins with a review of the meaning of mental retardation. As past research has been complicated by inconsistent definitions of mental retardation and the current definitions are interpreted in different ways, it is important to understand the complexity of the phenomenon of mental retardation to see how these complexities apply to the criteria of unfitness to stand trial.

Next, the doctrine of fitness to stand trial is examined. This involves an historical overview as well as a review of the present governing legislation. Existing research on the relationship between fitness to stand trial and MC persons shows how

individuals with mental handicap are disadvantaged at various stages of the psychiatric referral and assessment.

The research methods are presented next, followed by the research results. The results are discussed in the context of demographic profiles, psychiatric histories, criminal histories, and forensic assessments. The concluding remarks include the direction for future research as well as consideration of the future relationship between the issue of fitness to stand trial and MC accused persons.

Chapter Two

The Meaning of Mental Retardation[2]

One problem common to previous research in the field of mental retardation is the "inconsistent and idiosyncratic use of diagnostic categories" (Tanguay & Szymanski, 1984:405). Although the Diagnostic and Statistical Manual of Mental Disorders (DSM) helped to reduce these inconsistencies, there remains a "lack of homogeneity within labeled diagnostic groups" (Steinbock, 1976:30). The revised third edition of DSM (DSM-III-R) defines mental retardation as having three components:

> A. Significantly subaverage general intellectual functioning: an IQ of 70 or below on an individually administered IQ test
>
> B. Concurrent deficits or impairments in adaptive functioning, i.e., the person's effectiveness in meeting the standards expected for his or her age by his or her cultural group in areas such as social skills and responsibility, communication, daily living skills, personal independence and self-sufficiency
>
> C. Onset before the age of 18 (American Psychiatric Association, 1987:47).

This definition will remain unchanged in DSM-IV (American Psychiatric Association, 1991:C:1). Different levels of emphasis on the intellectual and adaptive functioning components result in inconsistent conceptualizations of the phenomenon of mental retardation.

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2 When the term "mentally retarded" is used, the use will conform to the terminology approved by the American Journal on Mental Retardation: Under no circumstances should "retarded" be used as a noun. Prepositional constructions such as "persons diagnosed with mental retardation" are preferred over adjectival constructions such as "mentally retarded people", except when clear communication dictates occasional use of adjectival designations. Direct quotes which do not conform to these guidelines will not be corrected, especially in references illustrating historical views.

In the past, levels of defect were used to categorize people diagnosed with mental retardation as "idiots", "imbeciles", "feeble-minded" or "morons" (Tizard, 1965). The three levels of intellectual impairment are now classified as:

> (a) severe retardation which involves gross central nervous system impairment and high frequency of multiple handicaps which affect the person's ability to assess and effectively participate in interpersonal social relationships
>
> (b) moderate retardation which involves a slower rate of development, problems with language, concrete approaches to problem solving, overreaction to minimal stresses, and proneness to hyperactivity, impulsivity, and rapid mood swings
>
> (c) mild retardation which involves vulnerability and high risk for failure in society. People diagnosed with mild mental retardation are frequently considered "society's misfits" rather than people with handicaps who require support (Eaton & Menolascino, 1982:1301).

A diagnosis closely related to mental retardation is borderline intellectual functioning. DSM-III-R (1987:204) indicates that "differential diagnosis between Borderline Intellectual Functioning [IQ in the 71-84 range] and Mental Retardation [IQ of 70 or lower] is especially difficult." When mental disorders are also present, borderline intellectual functioning may be missed in the process of diagnosis.

Intellectual Functioning

The degree of emphasis which should be attributed to the intellectual component of mental retardation has been the subject of much debate. The definitional issue has been explained as "whether persons with inefficient cognitive functioning should be considered mentally retarded, not whether retarded persons can succeed in everyday life" (Hodapp & Zigler, 1986:118). Also, there are competing theoretical views of the nature of mental retardation: Some contend it is primarily a thinking disorder which affects judgment and reasoning about the intrapersonal and interpersonal environment; while others consider mental retardation as primarily a learning

disorder which affects the processing and acquisition of new information and skills (Spitz, 1988).

There is also conflict about the utilization and stability of intelligence quotients as a measurement of intelligence:

> Intelligence quotients [IQ] are compound measures derived from number values assigned to successes on a range of diverse tasks graded for difficulty. The IQ is determined by the particular intelligence test used and is based on the intellectual behavior sampled by the test, the statistical treatment of the scores, the ratio of mental age to chronological age, and the standard deviation from the mean. Essentially, the IQ summarizes, in numerical language, a pattern of intellectual functioning (Morgenstern & Klass, 1991:199).

It has been argued that standardized intelligence tests are inappropriate because of test bias (i.e., they have not been standardized on minority groups), and disregard for environmental factors, such as malnutrition and poverty (Hetherington & Parke, 1986). As a result, IQ scores of people from different ethnic groups or lower social classes may not be accurate. It is important to note, however, that the IQ is only one component in the definition of mental retardation and it is improper "to rely solely on standardized measures of intellectual functioning in determining whether an individual is retarded" (Warren, 1977:5).

Others contend that, although intelligence tests are socially designed and administered, they are nonetheless valuable in assessing cognitive inefficiency, and that IQ is stable enough to serve as one criterion of mental retardation (Hodapp & Zigler, 1986). For example, in one study involving 101 "educable mentally retarded" children over a three-year period, the median change in IQ from test to retest was only 3.89 points in either direction (Silverstein, 1992). Furthermore, Barnett (1986:111) stated that "the IQ is merely an empirical measure that is used to classify people. The appropriateness of this operational definition depends in part on how

retardation is defined conceptually." Thus, for research purposes, utilization of IQ scores is helpful in determining the presence of mental retardation, especially if clinical diagnoses are not available.

Adaptive Functioning

The range of behaviours that are included in the concept of adaptive behaviour varies as a function of age and the meaning of social competence (Halpern, Lehmann, Irvin & Heiry, 1982). For example, included in the behaviours indicated in the DSM-III-R definition of mental retardation are capacities for functional independent skills, personal and social responsibility, motivation, physical development, and the requirement (or not) of regular medication (Leland, 1991). In adulthood, adaptive deficits that are the most important are "capacities for self-management (independence, social responsibility); employment; fulfillment of social roles (interpersonal roles); and community adjustment" (Baroff, 1974:23). Several instruments have been developed to measure various specific behaviours that are relevant to social functioning. For example, 20 different instruments assess a variety of behaviours including basic developmental skills, numerics and reading, communication, self-concept and self-awareness, emotional and personal adjustment, social and interpersonal skills, self-help skills, consumer skills, domestic skills, health care, knowledge of community, job readiness, vocational behaviour, and social behaviour at place of employment (Halpern et al., 1982). Measurements of adaptive behaviour are useful guides for program planning, program evaluation, and diagnosis and classification (Leland, 1977).

There is increasing acceptance that the relationship between intellectual functioning and adaptive behaviour is pivotal in understanding mental retardation.

Mental retardation is more than an individual characteristic--it encompasses the cognitive abilities of the individual and the abilities required by society:

> Mental retardation is fundamentally a deficit in mental efficiency. This implies that mental retardation is best understood as a status determined by an interaction between individual characteristics and societal demands. The individual's mental abilities must be appraised relative to society's requirements for success and survival. ... Accepting the importance of the social environment leads to the conclusion that IQ alone is an insufficient criterion for determining mental retardation (Barnett, 1986:115).

Baroff (1974) suggested that a cultural dimension must also be considered with respect to understanding mental retardation because a culture also imposes demands on its members. Thus, accurate assessment and classification of mental retardation depends on the particular characteristics of individuals, societies, and cultures (Barnett, 1986; Baroff, 1974).

The Difference Between Mental Disorder and Mental Retardation

The intellectual and behavioural components in the definition of mental retardation are the main features that differentiate mental disorder and mental retardation. In terms of cognition, "mentally ill people encounter disturbances in their thought process and emotions; mentally retarded people have limited abilities to learn" (Ellis & Luckasson, 1985:424). Another difference between mental disorder and mental retardation is a temporal difference. Mental disorder is frequently "temporal, cyclical, or episodic, whereas a developmental disability remains relatively constant through life" (Endicott, 1991:4). Mental disorder is not a developmental disability, and in most cases, mental disorders are treatable, especially through the use of medication (Montgomery, 1982).

Specific disorders have been identified as causes of mental retardation. These include tuberous sclerosis (tumors), microcephaly (an abnormal circumference of

the skull), phenylketonuria (a biochemical disturbance), cretinism (deficiency of thyroid hormone), and Down's Syndrome (congenital abnormalities) (Whitehead, 1982). These conditions are not causes of mental disorder.

Dual Diagnoses

Although there are differences between mental disorder and mental retardation, there are cases where persons diagnosed with mental retardation are also diagnosed with a mental disorder. This overlap is one of the reasons why individuals who are seen as mentally challenged at one time may not be seen as mentally challenged at another because, as Kirman (1979:5) indicated, "the prime problem in considering mental illness in relation to mental handicap is to distinguish between what is to be regarded as mental illness and what symptoms and aspects of behaviour may be thought appropriate to the degree of retardation." Treating the mental disorder may reduce the behavioural or emotional difficulties which may have exacerbated impairments related to the mental handicap. Furthermore, the diagnosis of mental disorder for an individual already diagnosed with mentally retardation becomes more difficult as the severity of the handicap increases (Ghaziuddin, 1988).

There are wide variations in the prevalence of mental disorder in the mentally challenged population. For example, various studies indicate prevalence rates of 5-10%, 14%, and as high as 59% (Singh, Radhakrishnan & Richardson, 1991). In a review of institutionalized persons with mental retardation, Parsons, May and Menolascino (1984:10) found that:

> the most consistent reports on the incidences of psychoses in the mentally retarded cluster around 4% - 6%. Most estimates of the incidence of serious psychiatric disorder, including both the personality disorders and the psychoses, range from 8% - 15%. When the minor emotional problems are included, estimates soar well above 50%.

In a two-year study on persons with mental retardation referred for competency evaluations, psychiatric diagnoses were made for 7.2% of the accused individuals (Reich & Wells, 1986). Also, a high percentage of people with mental disorders who were institutionalized were also reported to be "mentally retarded" (Parsons et al., 1984).

Individuals diagnosed with mental retardation appear to be slightly more susceptible to mental disorder than non-impaired individuals (Id.). Some factors which increase this vulnerability to mental disorder include medical fragility, peer group expectations to conform, frustration from repeated failures, humiliation from being constantly ridiculed, dependency, fears produced from trying to survive in a complex and impersonal society, and expectations to achieve beyond the person's intellectual and emotional capacity (Ruedrich & Menolascino, 1984). The high incidence of central nervous system impairment and the low, overall interpersonal coping abilities have also been cited as increasing the risk of the development of associated psychiatric disorders (Eaton & Menolascino, 1982). Therefore, individuals diagnosed with mental retardation may be "'at risk' for the development of psychiatric disorders, and it is clear that any condition that renders one less capable of handling reality-based demands makes one more susceptible to the development of mental illness" (Ruedrich & Menolascino, 1984:51).

Persons diagnosed with mental retardation also experience a variety of mental disorders. The most frequently reported mental disorders are psychoses (schizophrenia, manic-depressive psychosis, psychotic depression), anxiety disorders (conversion reaction, anxiety reaction, depressive reaction), personality disorders (schizoid personality, passive-aggressive, anti-social personality),

transitional-situational disorders (adjustment reaction to stress, adjustment disorders, symptomatic alcoholism, suicide gestures) and other disorders such as stereotyped behaviours (e.g., self-destructive acts) and confusional-aggressive episodes (e.g., seizures), (Id.). It is noted, however, that the existence of mental retardation does not prevent the successful treatment of concurrent mental illness (Id.). Successful treatment of the mental disorder permits maximization of the person's intellectual and social-adaptive capabilities.

The Relationship Between Mental Handicap and Criminality

Italian anthropologist, Cesare Lombroso, is largely responsible for the once popular belief that virtually all criminality could be attributed to mental defectiveness. Using biological criteria as the basis for his theory, Lombroso likened criminals to primitive beings.

> These people are innately driven to act as a normal ape or savage would, but such behaviour is deemed criminal in our society. Fortunately, we may identify born criminals because they bear anatomical signs of their apishness. Their atavism is both physical and mental, but the physical signs, or stigmata as Lombroso called them, are decisive (Gould, as cited in Linden, 1987:111).

Lombroso's theory of criminality was the foundation for the belief in a relationship between crime and mental retardation, for it was reasoned that "no man of intelligence could look on crime as a legitimate way of life; thus ipso facto, criminality derived from stupidity" (Pieski, 1962:769). In 1915, Henry Goddard (who served a term as president of what is now the American Association on Mental Retardation) wrote that "the moron ... is a menace to society and civilization; ... he is responsible to a large degree for many, if not all, of our social problems" (as cited in Ellis & Luckasson, 1985:418).

This idea that individuals with mental retardation possessed a proclivity for delinquency continued, largely unchallenged, until 1950 when a revisionist model of criminality and mental impairment gained popularity. According to the revisionist view, there was no relationship between crime and intelligence. But Luckasson (1988:355) stated that "[while] mental retardation cannot be said to cause criminality, we may have both overemphasized (during the historical period) and underemphasized (during the revisionist period) some connections between the two." The current view prevalent among some members of the scientific, legal, and correctional communities is that there no direct causal relationship between crime and mental impairment (Allen, 1970). This view has prevailed partly because of the absence of empirical research to support the belief that people with mental retardation are more likely to commit offences than non-impaired people (Bright, 1989).

It has been argued that MC individuals are more likely not "to take steps to avoid apprehension and arrest if they are associated with an incident that attracts the attention of law enforcement officers. Nor are they likely to be proficient at constructing alibis or deflecting blame onto someone else" (Endicott, 1991:17). Also, police usually have no easily available means to determine if an individual has mental retardation, and factors such as the influence of alcohol, language problems or uncontrolled behaviour may confound clues which would otherwise suggest mental retardation (Conley, Luckasson & Bouthilet, 1992).

The factors which may contribute to MC persons' criminal behavior are more likely to be associated with their treatment in society, rather than their "inherent nature as persons with disabilities" (Endicott, 1991:18). For example, such factors include the dumping of MC clients into society without follow-up care (French,

1983), poverty, social isolation, and frustration over repeated failures in various aspects of daily life (Endicott, 1991). These elements are apparent in the description of "typical" MC offenders. MacEachron (1979:167) explained that "[typical] retarded offenders, as reported in the literature, are in their late 20's or early 30's, nonwhite, left school between the sixth and eighth grades with a second- or third-grade equivalency, held low-skill jobs when employed, and live on welfare or poverty-level income." Therefore, social factors play an important role in the decision to commit criminal offences; mental retardation is not the "cause" of criminality.

There are conflicting reports concerning the types of crimes committed by MC persons. This dilemma may be attributed to inconsistent categorization of offences and/or inconsistent operationalization of MC offenders, as well as the source of statistics (e.g., prison populations or broader offender groups). Despite these discrepant results, it is still possible to speculate as to the types of offences MC persons are more likely to commit by considering the challenges they experience. For example, personality traits such as low frustration tolerance, poor impulse control, low level of motivation, and susceptibility to persuasion and manipulation (Santamour & West, 1982) may influence the commission of impulsive crimes rather than offences which require planning, deliberation, and delayed gratification (Ellis & Luckasson, 1985). In fact, a 1988 report by the Illinois Mentally Retarded and Mentally Ill Task Force concluded that "the overwhelming majority of offences committed by persons who are mentally retarded and/or mentally ill are misdemeanors, less serious felonies, and public disturbances" (as cited in Conley et al., 1992:40).

This does not mean, however, that MC individuals do not commit serious offences. Based on a small sample, Brown and Courtless (1971) found that homicides accounted for approximately 39% of offences committed by incarcerated intellectually impaired offenders. In another study, Sundram (1989) reported that 38% of intellectually impaired inmates had committed or attempted to commit murder, manslaughter, assault, robbery, kidnapping and sexual offences (as cited in Noble & Conley, 1992:39). Another study (Santamour, 1989:6) found that 38% of handicapped offenders committed breaking and entering, 13% committed homicide, and 5% committed sexual offences. It is important to note that these studies are based on inmates in correctional institutions which commonly house offenders convicted of serious crimes. Also, persons convicted of property crimes are more likely to be imprisoned (Endicott, 1991), thus explaining the unrepresentativeness of the inmate population. Finally:

> one would expect the percentage of severe crimes reported among all prison inmates to be greater than among new admissions, since inmates who commit the severe crimes will usually receive longer prison sentences and over time will represent an increasing proportion of inmates who remain in prison (Noble & Conley, 1992:40).

MC Persons in the Criminal Justice System

As early as 1970, it was acknowledged that mental retardation is a problem with which the criminal justice system must be concerned (State of Tennessee Legislative Council Committee, 1970). One of the reasons why people with mental retardation are not served well by the justice system is that, for many of them, their trust and submission to authority, passivity, and lack of contentiousness interferes with their ability to function as active participants in the legal system (Chellson, 1986; Perske, 1991). The courts have rejected the view that the suggestibility of MC

accused has an impact on admissibility of confessions. For example, in R. v. Sabean, (1979), the Nova Scotia Court of Appeal ruled that a confession was admissible despite proof that the defendant had an IQ in the range of 60 to 70 and had a mental age of 12. Also, the Ontario Court of Appeal in R. v. Tontarelli, (1982), stated that the accused's "rational" conversation with the police officers was indicative of an "operating mind", even though the court accepted that Tontarelli was "below average intelligence and prone to make bad judgments." Kaufman (1983) reported that courts tend to consider all of the circumstances of the case at bar, and that mental development is only one factor to be considered (e.g., R. v Arkell, 1980).

Second, as Schilit (1970:22) indicated, "[the] mentally retarded person who comes into contact with the criminal justice system is at a definite disadvantage due to the criminal justice system's unfamiliarity and uncertainty in dealing with mentally retarded individuals." Also, because of the stigma attached to mental retardation (Edgerton, 1967), many individuals try to hide their disabilities and pretend to understand their legal rights even if this is not the case (Perske, 1991; Rogers & Mitchell, 1991).

> [Offenders] with mental retardation tend to be aware of their disabilities and, whether motivated by mistrust of large systems or by fear of abuse, they generally work very hard to convince others that they do not have mental retardation. Therefore, they fail to take advantage of rights they have and don't understand; services they could benefit from (vocational and literacy training) they avoid because their disabilities may become apparent if they participate (Conley et al., 1992:11).

Because "adult mentally disabled have not been awarded additional protection like young offenders have" (Allen, 1970; Rogers & Mitchell, 1991:39), their experiences in the criminal justice system are often overwhelming.[3] For example,

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3 Accused are considered adults on the basis of their chronological age. This was affirmed in R. v. Ogg-Moss (1984), where the court held that the meaning of "child" is measured in terms of chronological age rather than in terms of intellectual capacity.

when an MC person must deal with police, the legal profession, and courts, "his possible confusion and inability to answer aggressive questioning may be mistaken for guilt or incompetence" (NIMR, 1981:78). Moreover, unfairness may result because criminal justice personnel often do not understand mental retardation sufficiently to represent MC defendants. As a result, "cases may be tried without even an awareness that the defendant has mental retardation, or of the effect of the disability on the ability of the defendant to assist counsel, to respond accurately and knowingly to questions or to understand the consequences of a guilty verdict" (Conley et al., 1992:xxi).

Bonnie (1990:439) suggested that the person with the greatest responsibility for detecting a mental disability is the defence counsel who must then compensate for her or his client's limitations:

> [in] cases involving defendants with normal intelligence, attorneys are likely to elicit relevant information regarding the offense, and are likely to explain the elements of legal guilt to the defendant. ... However, in cases involving defendants with subnormal intelligence, special precautions are required to offset the many factors which propel the system toward efficient outcomes rather than reliable ones.

Thus, fairness of adjudication depends on the identification of, and compensation for, an MC accused person's mental handicaps throughout the trial process.

Summary

The two significant components of the condition of mental retardation are intellectual functioning and adaptive functioning. Neither intelligence nor adaptive behaviour is reliable as a sole determinant of the presence of mental retardation. The description of mental retardation necessarily involves an assessment of intellect as well as an assessment of social adequacy or competency (Hunter, 1979). Also, mental

retardation must not be confused with mental disorder, although these two conditions may coexist.

MC individuals become involved in situations which attract law enforcement officials for a variety of reasons, not because of an inherent nature for criminality (Pierrel, 1985). From the point of apprehension and arrest through the trial and court disposition order, it is widely believed that MC persons are deprived of constitutional safeguards that are afforded to mentally disordered or non-impaired persons (Allen, 1970; Ellis & Luckasson, 1985; Haggerty, Kane & Udall, 1972). It appears that the values of fairness and accuracy, which form the foundations of justice, may be compromised when the defendant has mental retardation.

Chapter Three

The Legal Framework of Fitness to Stand Trial

The doctrine of fitness to stand trial is concerned "exclusively with the accused person's state of mind at the time of the trial and is directed exclusively toward ascertaining their [sic] ability to participate meaningfully in that trial" (Verdun-Jones, 1989a:214). The issue of fitness to stand trial is important for MC accused persons because "restoration" of competency is unlikely in most cases and, therefore, a pre-trial finding of unfitness often results in a bar to adjudication (Bonnie, 1990; Pierrel, 1985). The basic premise of the fitness doctrine is that "the state has no legitimate interest in punishing people because of their mental condition" (Hermann, 1990:361). Despite this premise, people with mental handicaps are often disadvantaged because of the emphasis on mental disorder as the basis for findings of unfitness.

Historical Background

The doctrine of fitness to stand trial can be traced to English common law which asserted that mentally incompetent defendants who were not both physically and mentally "present" at trial were denied the opportunity to defend themselves (Roesch, Eaves, Sollner, Normandin & Glackman, 1981; Verdun-Jones, 1981). As one of the formalities of the medieval court, it had to be decided if the defendant was mute of malice (and if so, was to suffer the "peine forte et dure"[4]) or mute by the visitation of God. In the latter case, the defendant was spared the "peine" and a plea of not guilty was entered on his behalf (Grubin, 1993). Over time, it was established that:

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4 The "peine forte et dure" involved starving the defendant and gradually crushing him under increasing weight until he either died or agreed to enter a plea (Grubin, 1993).

It is in this context that psychiatrists and other professionals trained in the area of developmental disabilities are of assistance to lawyers. Evaluations are most helpful when they provide an indication of the extent to which a mental handicap impairs an individual's reasoning ability and the manner in which the impairment may affect the defendant's perceptions during the trial process (Mickenberg, 1981). Identification of the defendant's reasoning ability is critical, especially if the individual is perceived as high-functioning, because functionality has little to do with comprehension level. It has been suggested that an ideal evaluation would consider the defendant's rigidity in thinking, expressive and receptive language, socialization skills, interactions with others, attention, memory, impulse control, immature or incomplete concept of causation, understanding of the social system, understanding of morality, self-concept, suggestibility, biased responding, motivation, intelligence quotients and adaptive behaviour (McGee & Menolascino, 1992). These factors all pertain to the overall ability of the defendant to participate fully in the trial, not just the ability to understand the personal import of the proceedings. Multi-disciplinary teams are useful in this aspect of evaluation (Mickenberg, 1981). Therefore, the ability to engage in abstract reasoning and comprehension of simple causal relationships are the main features to be considered when ascertaining whether the defendant understands the possible consequences of the criminal trial.

Ability to communicate with counsel.

Of the three criteria to determine the issue of unfitness to stand trial, the ability to communicate with counsel is the most crucial. Canadian courts have consistently recognized the importance of the defendant's ability to communicate with defence counsel (R. v. Budich, 1977; R. v. Hughes, 1978; R. v. Steele, 1991). This

of fitness to stand trial is that "an accused individual must be protected from a conviction that could have resulted from lack of participation or capacity to make proper judgments" (Roesch et al., 1981:145). If the defendant lacks minimal affective and cognitive resources, s/he is unable to "maintain an effective psychological presence in court" (McGarry, 1972:73), and therefore, the accuracy of the proceedings, the fairness of the trial, and dignity of the judicial process is brought into question (Stone, 1975).

Criteria for Unfitness to Stand Trial

Prior to 1992, the Code did not define unfitness to stand trial, and despite the obvious goals of the fitness doctrine, the lack of guidelines for assessing fitness resulted in variability in its application. The courts tended to define the term broadly (Verdun-Jones, 1989a). For example, in 1983 there were 74 findings of unfitness to stand trial in Quebec, 18 in Ontario, and 9 in British Columbia (Hodgins, 1988:331). Population size did not account for these considerable differences. Rogers and Mitchell (1991:96) acknowledged that the "noticeable absence of specific guidelines for assessing fitness to stand trial substantially contributes to its less than uniform application. In the absence of explicit criteria, forensic psychiatrists and psychologists often adopt rather idiosyncratic interpretations of fitness." Fitness to stand trial was viewed as a "standardless standard" (Id.).

Ambiguity is prevalent in other formulations and applications of the doctrine of fitness to stand trial in other jurisdictions as well. In the United States, for example, the definition of competency to stand trial was enunciated by the United States Supreme Court in Dusky v. United States, (1960): "The test must be whether [the defendant] has sufficient present ability to consult with his attorney with a reasonable degree of

rational understanding and a rational as well as factual understanding of the proceedings against him" (p. 403). Efforts to specify exactly what this definition means focus on two issues: "[The] defendant's capacity to understand the criminal process, including the role of the participants in that process; and the defendant's ability to function in that process, primarily through consulting with counsel in the preparation of a defense" (Melton, Petrila, Poythress & Slobogin, 1987:67). Research conducted in the United States has found that accused persons found incompetent "are more likely to be single, living alone, have previous psychiatric histories, lower IQs, and higher scores on several scales of the MMPI" (Daniel, Beck, Herath, Schmitz & Menninger, 1984:529).7

England and Wales, too, have grappled with the ambiguities inherent in the doctrine of fitness to stand trial. In this jurisdiction, the meaning of fitness to stand trial was expressed in R. v. Pritchard, (1836), in which the court ruled that fitness to stand trial requires the accused to have sufficient intellect to understand the proceedings so he could make a proper defence, challenge a juror to whom he might object, and understand the details of the evidence (as cited in Jefferson, 1992:211). In England and Wales there is no statutory definition of unfitness to plead (Jefferson, 1992), although there are basic criteria for a finding of unfitness that are related to Pritchard, supra. "The first is the ability to plead to the indictment, the second the ability to understand the course of the proceedings, the third the capacity to instruct a

7 The legal standard for competency to stand trial in the United States is the Dusky standard (i.e., the defendant must have the ability to, first, understand the nature of the criminal process and the role of the various actors involved, and second, assist counsel to prepare a defence). This is not to be confused by other competencies in the United States criminal process such as competency to plead guilty, which has a higher standard that competency to stand trial (Bonnie, 1993) and competency to waive constitutional rights which is different from competency to stand trial (Moran v. Godinez, 1992).

lawyer, the fourth the ability to challenge a juror and fifthly an ability to understand the evidence" (Mackay, 1991:6). Prior to 1992, an accused who lacked this understanding or was unable to plead to the charge was found unfit to plead under the Criminal Procedure (Insanity) Act, 1964, and hospitalized for an indefinite period at a place specified by the Home Secretary (Jefferson, 1992). Under the new act, Criminal Procedure (Insanity and Unfitness to Plead) Act , 1991, a jury (which hears two doctors) decides whether the accused is fit to plead. If the accused is found unfit, there is a trial of the facts during which a different jury decides whether the accused committed the actus reus of the offence, but the mental element (mens rea) is not considered. One study found that accused who were found unfit to plead between 1976 and 1989 were most likely to be male, between the ages of 20 and 39, and have previous criminal records and psychiatric histories (Mackay, 1991). As a diagnosis, "mental impairment" (21.2%) was second only to schizophrenia (56%) for individuals found unfit from 1976 to 1989 (Id., 5).

Although the Law Reform Commission of Canada (1976) made specific recommendations concerning the doctrine of fitness to stand trial in Canada, there were no significant changes in the Code until 1992. In February, 1992, the Code was amended to include the specific criteria necessary for a finding of unfitness to stand trial. Section 2 of the Code states:

> "Unfitness to stand trial" means unable on account of mental disorder to conduct a defence at any stage of the proceedings before a verdict is rendered or to instruct counsel to do so, and, in particular, unable on account of mental disorder to
>
> (a) understand the nature or object of the proceedings,
> (b) understand the possible consequences of the proceedings, or
> (c) communicate with counsel.

Further, this section of the Code defines mental disorder as a "disease of the mind."

The meaning of "disease of the mind".

The term "disease of the mind" developed primarily in relation to the old insanity defence in which a person was deemed insane if she or he had a disease of the mind to the extent that rendered her or him unable to appreciate the nature or quality of an act or omission or of knowing that an act or omission was wrong. The Supreme Court of Canada in Rabey v. The Queen, (1981) affirmed that a disease of the mind is any malfunctioning of the mind or mental disorder based primarily on some subjective condition or weakness internal to the individual which prevents the person from knowing what she or he is doing. The court also held that whether a condition constitutes a disease of the mind is a question of law for the judge to decide. In Bratty v. A-G for Northern Ireland,(1963) Lord Denning defined disease of the mind as "any mental disorder which manifested itself in violence and is prone to recur." English courts have grappled with this definition for some time, and have found that epilepsy (Bratty, supra; Regina v. Sullivan, 1983) and arteriosclerosis (Kemp, 1957) are diseases of the mind, but a hypoglycemic condition is not (Regina v. Quick; Regina v. Paddison, 1973). Canadian courts have concluded that epilepsy (R. v. Johnson, 1975)and delirium tremens (Regina v. Malcolm, 1989) are diseases of the mind, while somnambulism is not (Regina v. Parks, 1990). Galligan, J. A. of the Ontario Court of Appeal in Parks, supra, discussed the issue of disease of the mind as the cause of the accused's mental state:

> The medical evidence does not support a conclusion that a disorder or abnormal condition caused the impairment of the respondent's mental faculties. The thesis of the medical evidence is that impairment of the respondent's faculties of reason, memory and understanding was caused not by a disorder or abnormal condition but by a natural, normal condition--sleep. ... In a very

> real sense, sleep impairs the human mind and its functioning. Sleep, however, can hardly be called an illness, disorder or abnormal condition. It is a perfectly normal condition (p. 465).

The Supreme Court of Canada confirmed this definition on appeal (R. v. Parks, 1991). It has also been suggested that a disease of the mind must be a diagnosable condition (e.g., found in the Diagnostic and Statistical Manual of Mental Disorders), and that although this is necessary, it is not sufficient for classification as a disease of the mind (Maloney, 1985).

Emphasis on disease of the mind accounts for the tendency to dissociate mental retardation from the issue of fitness to stand trial. In Durham v. United States, (1954), the court indicated that a condition which was capable of improving or deteriorating was a "disease" and a permanent condition was a "defect." In Cooper v. The Queen, (1980), Justice Dickson of the Supreme Court of Canada defined disease of the mind as "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 states such as hysteria or concussion" (p. 144). In keeping with the ambiguity of the fitness doctrine, Justice Dickson failed to specify what constitutes a dysfunctional mind. It is arguable that if a human mind is impaired by subaverage intellectual functioning and this is an abnormal condition, then for legal purposes, mental retardation can be conceptualized as a disease of the mind according to the definition furnished by the Supreme Court of Canada.

Furthermore, application of the definition of mental disorder found in DSM-

III-R[8] to the definition of disease of the mind provided by Justice Dickson suggests that mental retardation is a disorder which impairs the human mind and its functioning. Also, England's Mental Health Act (1983, c. 20, s. 1(2)) defines mental disorder as "mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind" (emphasis added). The 1975 English Report of the Committee on Mentally Abnormal Offenders (Butler Committee) recommended that, for the purposes of fitness procedures, one of the characteristics of a severe mental illness be "lasting impairment of intellectual functions shown by failure of memory, orientation, comprehension and learning capacity" (as cited in Jefferson, 1992:221). If this definition had been accepted, mental retardation would amount to a mental illness for legal purposes. The various organic, psychological, social, and intellectual factors associated with mental retardation which affect the levels of an individual's functioning, achievement and societal participation also affect the functioning of the human mind (Fryers, 1987). Moreover, mental retardation is not a self-induced state, nor is it a transitory state; it is a developmental condition for which there is no cure. In addition, as Szasz (1990:72) argues, pathologists "who implicitly reject the reality or somatic basis of mental illness, do recognize the reality of the somatic basis of mental retardation." In this context, then, it is arguable that mental retardation is included within the mental health definition of mental disorder and the legal definition of disease of the mind as well.

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8 DSM-III-R defines mental disorder as "a clinically significant behavior or psychologic syndrome or pattern that occurs in an individual and that typically is associated with either a painful syndrome (distress) or impairment in one or more important areas of functioning (disability). In addition, there is an inference that there is a behavioral, psychological, or biological disfunction, and that the disturbance is not only in the relationship between the individual and society."

Ability to understand the nature or object of the proceedings.

Although the Code provides a definition of mental disorder, it does not explain what is meant by, nor the threshold for, the three standards for determining fitness. According to the first criterion, persons are unfit to stand trial if they are unable to understand the nature or object of the criminal proceedings. In Wieter v. Settle, (1961) a United States federal court stated that, with respect to procedural issues, defendants must have the mental capacity to appreciate their presence in relation to time, place, and things; have sufficient mental processes to understand that they are charged with a criminal offence and are in a court of law; understand that there is a lawyer who will try to prove that they committed the offence; understand that a defence lawyer will help them in their battle to avoid conviction; and understand that a jury will decide if they are guilty or innocent. The individual's comprehension of these issues need not be elaborate--a simplistic but accurate understanding will suffice. For example, a defendant who has a naive and unsophisticated understanding of the criminal justice system, personnel, and courtroom procedure will be fit to stand trial if she or he is aware that a judge or jury will determine guilt or innocence, understands that the defence lawyer will advocate for her or his interests, and have a rudimentary understanding of the adversarial nature of the criminal justice process (Sauget, Wightman & Everett, 1988). In contrast, a defendant who is unaware of the role of witnesses, confuses the jobs of defence lawyer and Crown counsel, or does not understand legal terms such as "sentence" or "probation" lacks the rudimentary understanding of the nature or object of the criminal proceedings (Thompson & Boersma, 1988).

Thus, to meet the first criterion indicated in the Code, an MC defendant need only have the capacity or ability to understand the basic roles of criminal justice personnel. Mere knowledge that she or he is "in trouble" is not sufficient. The adequacy or accuracy of the defendant's understanding is the key.

Ability to understand the possible consequences of the proceedings.

The second criterion expressed in the Code concerns the defendant's ability to understand the possible consequences of the proceedings. This requires a capability of abstract reasoning. For the individual to understand the cause-and-effect relationship between testimony, verdict, sentence, and punishment, she or he must have sufficient reasoning skills to interpret the implications of testimony and the judge's decision concerning the criminal charges (Mickenberg, 1981). This means that the defendant must be capable of simple, abstract reasoning.

Perske (1991:17) indicates the possible consequences resulting from the inability to abstract from concrete thought:

> Unfortunately, concrete-thinking people may quickly and unabashedly waive their right to be silent and their right to a lawyer. They may fail to understand the abstract meaning of the term right. Some may think they are being asked to "wave at the right" rather than at the wrong. After all, nobody waves at the wrong in a police station. Others may think it has to do with right versus left. And even if some know it means more than that, they still don't catch the abstraction that they are giving up their constitutional rights as a citizen.[9]

The mere presence of developmental disability does not necessarily lead to the conclusion that the defendant cannot understand the possible consequences of the proceedings--the significance of the disability is measured in terms of the severity of the impairment in functioning and the causal connection between the impairment and

9 Ironically, in United States v. Wenzel (1980), the court ruled that there was no bona fide doubt even though the defendant had only a third- or fourth-grade ability in reading, writing, and arithmetic, and was unable to think abstractly on a proverbs test.

the resulting dysfunction (Ellis & Luckasson, 1985; Shah, 1989). In this respect, special efforts to explain the consequences and assist the defendant in understanding them may reduce the effect of the disability as applied to this criterion for unfitness to stand trial. For example, in State v. Williams, (1978), the deaf-mute defendant was unable to communicate with counsel. The court stated that, if the defendant's communicative skills could be improved so that he could assist counsel in his defence, he could be tried, provided that the restorative procedures could be provided without delay. If not, he must be released. Also, in People v. Jackson, (1982), the court held that establishment of an effective way of communication for the hearing-impaired defendant would satisfy the standards of due process.

Because cognitive deficits and concrete coping mechanisms modify an MC individual's response to environmental stresses and may result in inappropriate reaction to "ordinary everyday provocation" (Ghaziuddin, 1988:495), one of the factors to be considered is the type of trial the defendant is expected to stand (State of Tennessee Legislative Council Committee, 1970). The context of the specific trial must be taken into account as a "complex" trial requires a greater degree of capability than that which is necessary for a "simple" trial. It is important, therefore, to consider the accused in the context of a supportive relationship with her or his counsel rather than to look at her or his disabilities and capabilities in a vacuum. As McGarry (1972:73) explains, "whether or not the person has physical or psychological defects is irrelevant except to the extent that they substantially interfere with fitness for trial." A defendant who is properly assisted may have the ability to understand the personal consequences of the proceedings.

It is in this context that psychiatrists and other professionals trained in the area of developmental disabilities are of assistance to lawyers. Evaluations are most helpful when they provide an indication of the extent to which a mental handicap impairs an individual's reasoning ability and the manner in which the impairment may affect the defendant's perceptions during the trial process (Mickenberg, 1981). Identification of the defendant's reasoning ability is critical, especially if the individual is perceived as high-functioning, because functionality has little to do with comprehension level. It has been suggested that an ideal evaluation would consider the defendant's rigidity in thinking, expressive and receptive language, socialization skills, interactions with others, attention, memory, impulse control, immature or incomplete concept of causation, understanding of the social system, understanding of morality, self-concept, suggestibility, biased responding, motivation, intelligence quotients and adaptive behaviour (McGee & Menolascino, 1992). These factors all pertain to the overall ability of the defendant to participate fully in the trial, not just the ability to understand the personal import of the proceedings. Multi-disciplinary teams are useful in this aspect of evaluation (Mickenberg, 1981). Therefore, the ability to engage in abstract reasoning and comprehension of simple causal relationships are the main features to be considered when ascertaining whether the defendant understands the possible consequences of the criminal trial.

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requirement was explicitly stated in Rex v. Kierstead,(1918) when Justice Chandler advised the jury to consider whether the accused's mind was so diseased that he could not instruct his counsel intelligently or converse with defence counsel.

In R. v. Demontigny, (1990), Justice Pinard of the Quebec Supreme Court indicated the scope of the phrase, "ability to communicate with counsel":

> [The defendant] must be able both to receive the counsel of his attorney, to ask him for it when necessary, to instruct him and to make choices, fully appreciating the consequences. Of course, he must be able to give a true account of what took place. ... [He] must be able to express it to his attorney so that his attorney can understand. In short, he must be able to establish an effective working relationship between himself and his counsel, a relationship where confidence, of course--regardless of whether complete or only partial--is not excluded. Common sense at least suggests that. In short, he must be able to function in order to conduct his defence alone or with the help of an attorney (pp. 4-5).

It is a conflict with common law and a violation of fairness to bring to trial an accused who is unable to participate fully in her or his trial (Roesch et al., 1981). So, in order to be capable of conducting her or his defence, the defendant must be able to communicate with counsel, converse with counsel rationally, make critical decisions based on counsel's advice, and if necessary, testify. Adequate participation in the accused's own defence is necessary; otherwise, she or he should not be subjected to the "rigours of a criminal trial" (Verdun-Jones, 1981:363).

Eloquent expression of wishes is not relevant in this matter. For instance, in R. v. Hughes, (1978), the Alberta Supreme Court indicated that a subaverage intelligence level that prevents an accused from expressing himself as well as others did not affect the accused's capacity to defend himself. Furthermore, "competency does not turn on the extent to which others regard an individual's decisions as reasonable" (Hermann, 1990:380); competence to act rationally is a crucial factor (Fingarette, 1972). Bonnie (1990) suggests that for defendants with mental retardation, the

disabilities that require attention are those which are related to the ability to recall and describe relevant events, including states of mind. Thus, it is less useful for psychiatrists or psychologists, especially if untrained or inexperienced in the area of mental retardation, to offer a professional opinion regarding the defendant's ability to communicate effectively with counsel, for it is the lawyer who knows what this communication will entail. As Fersch (1979:99) stated, it is "ironic that the matter of the defendant's competency to work with his lawyer is removed from the legal profession and turned over to the psychiatric profession for resolution."

When MC accused cannot adequately relate information regarding the alleged offence to their lawyers and the lawyers do not adequately explain defence options and trial procedures, substantial reliability is compromised (Bonnie, 1990). Also, elements of due process are threatened if an MC person does not receive a thorough explanation of the complexity of her or his case, as well as the various defence strategies available. The Supreme Court of Canada recently affirmed in R. v. Evans, (1991), that courts must be satisfied that the defendant is capable of making reasonable decisions. This requires that the individual have at least a basic level of knowledge and comprehension (Rogers & Mitchell, 1991).

Summary.

In summary, the definition of mental disorder as a disease of the mind appears to bring into question the issue of fitness to stand trial as being relevant to mentally challenged defendants. The definition of mental disorder in DSM-III-R as well as Justice Dickson's definition of disease of the mind imply that, for the purpose of this legal doctrine, mental retardation should be classified as a disease of the mind. Alternatively, the term "mental disorder" should be redefined. The first criterion for

unfitness to stand trial as indicated in the Code, that is, ability to understand the nature or object of the proceedings, requires only a rudimentary understanding of the basic roles of criminal justice personnel. The second criterion, the ability to understand the possible consequences of the proceedings, requires, at minimum, the capability of abstract reasoning and comprehension of causal relationships. The third criterion, the ability to communicate with counsel, may be the most important issue concerning whether a defendant is fit to stand trial. The question is not whether the defendant can act in her or his best interests; rather, the defendant's ability to form an effective working relationship with her or his lawyer is the issue. Bonnie (1993:554) set out the minimum conditions required for a defendant's participating in his or her own defence:

> 1) capacity to understand the charges, the purpose of the criminal process, and the adversary system, especially the role of defense counsel [factual understanding]; 2) capacity to appreciate one's situation as a defendant in a criminal prosecution [rational understanding]; and 3) ability to recognize and relate pertinent information to counsel concerning the facts of the case [necessary cognitive processes].

Problems arise, however, when defence counsel, or indeed, other criminal justice personnel, lack training or practical experience in dealing with MC persons (Conley, Luckasson & Bouthilet, 1992; Hitchen, 1993; Perske, 1991; Sauget, Wightman & Everett, 1988; Schilit, 1979). The fact that criminal justice personnel are untrained and inexperienced in the needs of MC accused raises questions about whether defendants receive fair treatment, adequate representation, or a fair trial.

Disposition of Unfit Accused Persons

Several cases involving disabled persons highlight the deprivation of liberty associated with the detention of persons not even convicted of offences. For example, Donald Lang, an illiterate deaf-mute was found unfit to stand trial and subjected to

indefinite incarceration despite no determination of guilt (Roesch & Golding, 1980; Paull, 1993). His defence argued for the right to proceed to trial and the Illinois Supreme Court ruled that "this defendant, handicapped as he is and facing an indefinite commitment because of the pending indictment against him, should be given an opportunity to obtain a trial to determine whether or not he is guilty as charged or should be released" (People ex rel. Myers v. Briggs, 1970:288). Lang has been incarcerated for over 26 years.

The case of Emerson Bonnar is another illustration of the problem. Bonnar, a mentally challenged 19-year-old, had no previous criminal record at the start of his 16-year odyssey that began with a failed purse-snatching attempt. Had he pled guilty to the offence of attempted robbery, a 16-year sentence would have been labeled as preposterous. Savage (1981) has complained about the confused wording and lack of procedural safeguards for persons with a mental handicap or an inability to communicate clearly, as well as hearing-impaired persons who are mistaken as mentally ill, or mentally ill persons.

In a different twist to the problem of MC defendants accused but not convicted of a criminal offence, White (1992:5) described the case of a deaf-mute male with limited intelligence who was charged with burglary. He was incarcerated for one week, then sent to a hospital for mentally challenged individuals for three months, then discharged to his parents, even though this was his third appearance in court. This case may be used to illustrate the dilemma that arises when "the degree of mental impairment is not sufficient to justify compulsory detention in hospital, nor civil commitment to hospital, nor a hospital or guardianship order without convicting the defendant."

Prior to 1992, persons found unfit to stand trial were held in custody under a Lieutenant Governor's Warrant. The problem of indefinite incarceration of persons not convicted of offences was recognized as early as 1972 by the United States Supreme Court in Jackson v. Indiana. The court ruled that:

> a person charged by a State with a criminal offense who is committed solely on account of his incapacity to proceed to trial cannot be held more than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain that capacity in the foreseeable future (p. 738).

In 1991, the Supreme Court of Canada in R. v. Swain declared the system of automatic detention, as stated in Section 614(2) of the Code, unconstitutional because it violated Section 7 (the right to life, liberty, and security of the person) and Section 9 (the right not to be arbitrarily detained) of the Canadian Charter of Rights and Freedoms.

Now, Section 672.45 of the Code states that, when accused persons are found unfit to stand trial, the court may, of its own motion, or on the application of the accused or Crown Attorney, hold a disposition hearing. A Review Board will make a disposition order within 45 days after the verdict of unfit to stand trial has been rendered, if the court does not.[10] Section 672.54 of the Code describes the criteria to be considered by the court or Review Board when making dispositions:

> Where a court or Review Board makes a disposition ... it shall, taking into consideration the need to protect the public from dangerous persons, the mental condition of the accused, the reintegration of the accused into society and the other needs of the accused, make one of the following dispositions that is the least onerous and least restrictive to the accused:
>
> (b) by order, direct that the accused be discharged subject to such conditions as the court or Review Board considered appropriate; or
>
> (c) by order, direct that the accused be detained in custody or in a hospital, subject to such conditions as the court or Review Board considers appropriate.

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10 This requirement is stated in Section 672.47(1) of the Code. There are also provisions in this Section for extending the time for holding a hearing to a maximum period of 90 days, under "exceptional circumstances".

A third disposition option with respect to persons found unfit to stand trial is described in Section 672.58:

> Where a verdict of unfit to stand trial is rendered and the court has not made a disposition under section 672.54 in respect of an accused, the court may, on application by the prosecutor, by order, direct that treatment of the accused be carried out for a specified period not exceeding sixty days, subject to such conditions as the court considers appropriate and, where the accused is not detained in custody, direct that the accused submit to that treatment by the person or at the hospital specified.

Section 672.64(3) of the Code describes the provisions for "caps," or maximum periods for detention, on dispositions. Generally, these caps are for periods of life for murder or treason, ten years or the maximum period during which the accused is liable to imprisonment (whichever is shorter) for the more serious offences that are prosecuted by indictment, and two years or the maximum period during which the accused is liable to imprisonment (whichever is shorter) for all other offences. Also, the Crown is required to prove a prima facie case every two years. If the court is satisfied that sufficient evidence cannot be adduced to put the accused on trial, the court must acquit the accused.

For MC accused persons found unfit to stand trial, this system reduces the possibility of disproportionately long periods of incarceration without the benefit of a trial. But as Miller (1980) pointed out, people with mental retardation are not "sick". This raises a dilemma because no treatment will "cure" MC accused persons' mental disabilities. Also, an MC accused will not achieve fitness to stand as a result of time alone; thus, the system of capping presents few favorable benefits other than the reduced possibility of indefinite detention.

Fitness of MC Accused Persons

The presence of mental retardation does not necessarily lead to a verdict of unfitness to stand trial, and past research does not provide consistent results of the effect of mental retardation on fitness decisions. For example, one study found that "education and reading level are significantly related in that the higher the educational attainment, the greater the chance for being found competent and responsible" (Daniel et al., 1984:541). Nicholson and Kugler (1991) reviewed eight studies involving 882 individuals. They found a "negative correlation between IQ and competency status indicating that incompetent defendants scored lower on standard IQ tests than did competent defendants" (at p. 360). They also complained, however, that most studies did not include sufficient information to classify defendants according to the degree of mental retardation. A review of 12 studies involving 2,266 individuals found a small correlation between a diagnosis of mental retardation and competency status, while another review of 11 studies indicated that "the proportion of defendants considered incompetent did not vary greatly as a function of the presence or absence of a diagnosis of mental retardation" (Nicholson & Kugler, 1991:359). Other literature (Paull, 1993:16) indicates that IQ is not a relevant factor and that IQs ranging from 37 to 72 did not raise a bona fide doubt of fitness. Quinsey and Maguire (1983:195) conducted a study in Ontario which indicated that, of 200 individuals remanded for psychiatric examination in a mental health institution, 15 were diagnosed as mentally retarded and of these 11 were recommended as being fit to stand trial. A behavioural component was cited as the significant factor in another study. "The presence of pathological behaviors was used more frequently to describe the group for whom competency to stand trial evaluations were requested; the defendants for whom competency was not

evaluated were more frequently described as being aware of their legal situation" (Berman & Osborne, 1987:378). In People v. McNeal, (1981), the fact that the defendant had a WAIS IQ score of only 61 did not raise a bona fide doubt because of other professional opinions regarding the defendant's fitness to stand trial. Therefore, it appears that intellectual ability is a factor, albeit an indefinite one, in the determination of fitness to stand trial.

Summary

The doctrine of fitness to stand trial promotes fairness to accused individuals by protecting their right to defend themselves and ensures that they are appropriate subjects for criminal trials (Verdun-Jones, 1989a). The law seeks to ensure that "only the acts of a rational individual are to be given recognition by society" (Melton et al., 1987:65). It is not mere presence of a mental disorder that determines the fitness of the accused--it is the manner in which the disorder affects the abilities of the individual during the trial process.

Because of the Code's continuing emphasis on mental disorder (i.e., disease of the mind), the fitness doctrine is similar to the defence of Not Criminally Responsible on Account of Mental Disorder: there is a need to "draw a sharp distinction between the mad and the bad" (Verdun-Jones, 1989b:2). The ambiguity surrounding the definition of disease of the mind, however, leaves open the opportunity for the judiciary to include mental retardation as a disease of the mind for the purposes of fitness to stand trial.

Prior to 1992, a finding of unfitness to stand trial meant that "the defendant [would] not get his day in court and [would] remain in limbo as to the criminal charges against him until competency [was] restored" (Stone, 1975:203). This is

troublesome for individuals with mental retardation, as competence will not be "restored"; however, the 1992 amendments to the Code concerning dispositions and the courts' attention to the Canadian Charter of Rights and Freedoms reduce the possibility of indefinite incarceration for individuals found unfit to stand trial.

Chapter Four

Methods

In the present study, archival information from the British Columbia Forensic Psychiatric Institute (F.P.I.) was gathered to evaluate the relationship between fitness to stand trial and MC individuals. A research proposal was submitted to the Forensic Psychiatric Services Commission for approval, and the Executive Director of the Commission granted access to the file data (see Appendix E).[11]

Setting

The Institute provides court-ordered assessments for people accused of criminal behaviour and is responsible for the custody of individuals remanded for psychiatric evaluations. Also, F.P.I. provides treatment and custody for mentally disordered individuals committed to the Institute, and assists in managing mentally disordered defendants in the criminal justice system.

Data was gathered from the medical and legal files of those persons remanded to F.P.I. in Port Coquitlam, British Columbia, for psychiatric assessment. These files yield medical information including psychiatric diagnoses (based on the Diagnostic and Statistical Manual of Mental Disorders), psychiatric history, and psychiatrist's recommendations, as well as legal information such as previous and current Code offences and convictions.

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11 In the research proposal submitted to the Forensic Psychiatric Services Commission, Ms. Faye E. Grant, a Policy and Program Analyst at the Commission, was listed as co-investigator because she supplied the database from which subjects were selected, indicated which information was obtainable from the files, and assisted by sharing other relevant information.

When a person is admitted to F.P.I., s/he is given a patient number, and an admission number, with the most recent admission first.[12] The first page of the file states identification information, such as name, address, birth date, and admission date and discharge date, as well as the psychiatrist's name, DSM diagnoses, and the psychiatrist's recommendation (e.g., fit or unfit to stand trial). Following this is information regarding education, employment, income source, and living arrangements.[13] Reports by psychiatrists and nurses are followed by medical reports and nursing notes. The legal file contains the police report and other legal documentation as well as copies of the psychiatrist's letter to the court for each admission.

Court-ordered assessment orders are written on standardized forms which indicate the requested evaluations. These orders may request assessment of existence of mental illness, fitness to stand trial, mental state at time of the offence, psychiatric treatment requirements, and pre-sentence report with recommendations. Earlier forms also requested assessment for the individual's certifiability under the Mental Health Act (i.e., involuntary patient). The 1992 Code amendments introduced a new form for use on a national basis which indicates the issues that could be examined in a psychiatric remand. These issues include fitness to stand trial, not criminally responsible on account of mental disorder (NCRMD), mental state of a woman charged with infanticide, disposition, and hospital orders.

The psychiatric reports as well as the letter to the court usually began with a statement indicating which assessment or assessments were required, (e.g., "Patient X

12 Some patients who had numerous admissions to F.P.I. had volumes of files.

13 In the two latter study years, more information was recorded concerning patients admitted than was recorded in the initial year (e.g., living arrangements).

was referred to the Forensic Psychiatric Institute for assessment of the existence of mental illness, fitness to stand trial, and mental state at the time of the offence .")[14]

Subjects

All individuals diagnosed as mentally retarded who were remanded for psychiatric evaluation during each study year were included in this research. A person remanded more than once during the study year (i.e., multiple remand) was treated as a separate subject for each admission.[15] Subjects were classified as MC, non-MC, or dual-diagnosed based on medical documentation specifying clinical diagnoses. The number of MC subjects and dual-diagnosed subjects was dictated by the number of remanded persons clinically diagnosed as mentally retarded and without a coexisting clinical syndrome or diagnosed as both mentally disordered and mentally retarded in each study year.

For each study year, a comparison group comprised of non-MC subjects was formed. A subject was eligible for inclusion in the comparison group if she or he was not clinically diagnosed as mentally retarded. The number of subjects in each year's comparison group was ten, regardless of the number of MC subjects and dual-diagnosed subjects in any study period.

Method

Sampling.

Systematic sampling was used to select subjects for the non-MC group using a

14 Initially, the coding manual included a question asking which party (i.e., the judge, defence counsel, or crown counsel) requested the assessment. It was later decided to remove this question because of uncertainty about the accuracy of the identity of the requesting party.

15 Two dual-diagnosed subjects in the anticipatory year and two dual-diagnosed subjects in the final year had multiple remands, i.e., two remands in the study year.

numerically-arranged list of admissions for each study year. If the file chosen could not be used (e.g., if the admission number was missing), the next subject on the list was chosen.[16] Any problems which made the file unusable were not discovered until the complete list of subjects had been completed and Medical Records personnel at F.P.I. had drawn the files. All subjects with a diagnosis of mental retardation comprised the MC and dual-diagnosed groups for each study year.

Procedure.

A coding manual (see Appendix A) was used to record information from the patients' files. All data was archival. The nature of the subjects' situation at F.P.I. (i.e., charged with criminal offences and awaiting trial on these charges) precluded interviews with them. Formal interviews were not conducted with psychiatrists because their reports were conclusive. Furthermore, there were 12 psychiatrists who conducted the assessments over the three study years, and of the six psychiatrists who conducted assessments in the final study year, only one had conducted assessments in all three study years.[17]

The Research Question

The research question was two-pronged: The first question asked whether MC individuals remanded to a mental health institution for psychiatric evaluation were processed differently from non-MC individuals remanded for such evaluations. The second question asked whether the 1992 amendments to the Code affected the processing of MC people remanded for psychiatric evaluation.

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16 For each study year, there were approximately 200 referrals from which non-MC, MC, and dual-diagnosed subjects were selected.

17 Implications of the high turnover rate of psychiatric staff are dicussed in Chapter Six.

Seven subsidiary questions also guided the research. First, the research sought to identify whether, based on demographic profiles, there were differences among MC accused, non-MC accused, and dual-diagnosed accused remanded for psychiatric evaluation. A mentally challenged accused (MC accused) is a person who has been clinically diagnosed as mentally retarded by a psychiatrist. DSM-III-R defines mental retardation as significantly subaverage intellectual functioning (an IQ of 70 or below) with concurrent deficits or impairments in adaptive functioning with onset before the age of 18. A non-mentally challenged accused (non-MC accused) is a person who has not been clinically diagnosed as mentally retarded. A dual-diagnosed accused is a person who has been diagnosed as both mentally disordered and mentally retarded.

Second, the study sought to identify any differences among the three groups based on psychiatric and criminal histories. Included in the probe into psychiatric history were past admissions to mental health institutions including F.P.I. Criminal history included information such as previous offences and prior convictions.

The third goal of this research was to determine the incidence and nature of mental handicap in remanded persons in each study year. There were three study years:

Baseline Year, February, 1985 to February, 1986. This baseline year represented a period after which the DSM-III-R diagnostic criteria were established, but before the changes to the Code were anticipated.

Anticipatory Year, February, 1990 to February, 1991. This period preceded the amendments to the Code.

Final Year, February, 1992 to February, 1993. This time frame represented the first year after which the Code amendments had been implemented.

Fourth, it was asked what, if any, psychometric testing was done on each group in each study period, and if the psychological tests administered differed among the groups.

Fifth, the psychiatrists' recommendations were recorded for each group and it was asked whether the basis for these professional opinions changed over time. Psychiatrists made recommendations based on requests by the court (or Crown Counsel or Defence Counsel) for professional opinions concerning the accused person's mental state.

Sixth, it was asked if, and how, a diagnosis of mental retardation affected the forensic clinicians' recommendations regarding fitness to stand trial of accused persons during the baseline, anticipatory, and final years.

The final research goal was to determine the incidence and nature of diagnoses of mental retardation and dual-diagnoses among individuals remanded for psychiatric assessment during each study period.

Research Concerns

During the course of data collection, several problems arose. First, a nursing job action was in effect at F.P.I. from June 6, 1990 to July 26, 1990. As a result, some information that was usually recorded was missing for this period. For example, the nurses routinely summarized the patients' psychiatric background and recorded their responses to questions such as naming six large cities and explaining proverbs. Some of the information missing from the nurses' reports could be found in other reports in the patients' files. Second, there were two problems related to diagnoses: there were files with no diagnoses recorded and others had diagnoses recorded that were not found in DSM-III-R. In instances where the diagnosis could not be found in

the file, it was recorded as a deferred diagnosis for this study. For diagnoses not found in DSM-III-R, the diagnosis was classified according to the clinician's written description (e.g., speech and hearing deficits). For other problems, there was no simple solution--a missing file (e.g., admission 2 but not admission 1), or information not recorded in the baseline year but routinely recorded in subsequent years (e.g., source of income at the time of remand).

Chapter Five

Results

Sociodemographic Characteristics

The total number of subjects was 52: 30 non-MC, 8 MC, and 14 dual-diagnosed accused. (See Table 1.) In the Baseline Year, only three individuals remanded to F.P.I. for evaluations were diagnosed as mentally retarded and none were dual-diagnosed. In the Anticipatory Year, there were four individuals diagnosed with mental retardation and eight dual-diagnosed, and in the Final Year one person was diagnosed with mental retardation and six were dual-diagnosed. Males accounted for 92% of the subjects (n = 48).

Natives[18] were over-represented in the dual-diagnosed groups in the Anticipatory Year (62.3%) and in the Final Year (50%). In contrast, Natives accounted for less than 20% of non-MC accused in each study year.

The majority of all subjects in each group was unemployed. No MC subjects and only one dual-diagnosed subject indicated that they held full-time jobs, and one MC subject indicated that he had part-time employment.[19]

The mean age of non-MC subjects at the time of remand was 37.35 years. The youngest person was 18.55 years old and the oldest person was 61.35 years old (median = 36.29 years). The mean age of MC subjects at the time of remand was

18 This is the term used in the files, and included status and non-status Natives, based on self-reporting.

19 Source of income at the time of remand was not reported as this information was missing for the Baseline Year. For the remaining study years, welfare and government pensions were the income sources for 63.2% of the non-MC subjects, 80% of the MC subjects, and 61.5% of the dual-diagnosed subjects for whom income source was known.

25.85 years. The youngest subject was 21.25 years old and the oldest was 40.35 years old (median = 23.18 years). For the dual-diagnosed group, the mean age at time of remand was 32.92 years. The youngest person was 18.16 years old and the oldest person was 66.47 years old (median = 28.81 years).

An analysis of variance indicated that the variability in age at the time of admission for the three groups was statistically significant ($F=3.286$, $p<.05$). This is explained by the greater variability of the ages of the non-MC and dual-diagnosed subjects (standard deviation of 10.82 and 14.82), whereas the ages of the MC subjects were clustered in the 20's (standard deviation of 6.46).

Table 1

Demographic Characteristics by Group

Variable	Non-MC	MC	DD
Gender			
Male	28	7	13
Female	2	1	1
Race			
Native	4	0	8
Non-Native	26	8	6
Employment			
Full-time	2	0	1
Part-time	3	1	0
Occasional	0	1	1
Unemployed	23	6	11
Other	2	0	1
Age (Years)			
25 or younger	6	5	5
26 - 35	8	2	7
36 - 45	9	1	0
46 - 55	5	0	0
55 or older	2	0	2

Psychiatric History

Previous admission to mental health institutions.

Of the non-MC group, 11 subjects had no previous admissions to a mental health institution, including F.P.I. All MC subjects and all but one of the dual-diagnosed subjects had previous admissions. Six non-MC subjects, one MC subject, and two dual-diagnosed subjects had extensive histories[20] of admissions to mental health institutions.

For the total previous mental health admissions of non-MC subjects, 33.3% were for a period of one to seven days, 33.3% were for a period of 15 to 30 days, and 22.2% were for a period longer than one year. In the Baseline Year, non-MC subjects had a total of 12 prior admissions[21]; in the Anticipatory Year, they had nine prior admissions; and in the Final Year, there were only six previous admissions to mental health institutions.

The history of admissions to mental health institutions was known for five of the eight MC subjects. The total number of admissions was 14. Every subject had at least two previous admissions and one subject had an extensive history of admissions. Three admissions (21.4%) were for periods of 15 to 30 days, two (14.1%) were for periods of 31 to 60 days, three (21.4%) were for periods over 60 days but less than one year, and five (35.1%) were for periods over one year. One MC subject in the Anticipatory Year had lengthy admissions (i.e., over one year).

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20 An extensive history was one in which the subject had a high number of admissions to mental health institutions, regardless of the length of stay for each admission.

21 The four most recent admissions to mental health institutions were recorded for each subject. The current remand to F.P.I. was excluded.

Of the 11 dual-diagnosed subjects for whom admission history was known, only one subject (in the Anticipatory Year) had no previous admissions to a mental health institution. Of the other subjects who had a total of 23 previous admissions, 20% had admissions for periods of one to seven days, and 35% had admissions which lasted longer than one year. Two subjects, both in the Anticipatory Year, had extensive histories of mental health institution admissions. One subject had been institutionalized for 25 years, and the other had spent many years at Woodlands Hospital, a facility for mentally challenged people.

Intelligence Quotient.

Intelligence quotients (IQ) were reported for 19 non-MC, 7 MC, and 13 dual-diagnosed patients.

Table 2

IQ Rating by Group

IQ Rating	Non-MC	MC	DD
Average to above average IQ above 85	13	0	0
Borderline mental retardation IQ 71 - 85	5	3	1
Mild mental retardation IQ 50 - 70	0	3	7
Moderate mental retardation IQ 35 - 49	0	0	2
Indeterminate	1	1	3

The indeterminate IQ for the non-MC subject was the result of unsuccessful testing. The MC subject who received an indeterminate rating had conflicting IQ scores--one score of 90 and another score of 75. For the indeterminate ratings for the dual-diagnosed subjects, one patient had scores which put him in either the range of borderline mental retardation or mild mental retardation, and testing was unsuccessful for the other subjects because of a low level of functioning.

An IQ score in the range of borderline mental retardation for patients not diagnosed as mentally retarded may result from several factors. For example, psychiatric interpretations of test results, a co-existing mental disorder, and learning disabilities, may result in low scores on intelligence tests. Also, a diagnosis of mental retardation is not made on the sole basis of a low IQ score.

Criminal History

Only nine subjects (17.31%) had no formal record of criminal charges.[22] Forty-three subjects had been previously charged with a Code offence, including 26 non-MC, four MC, and 13 dual-diagnosed subjects.

The three most recent convictions for criminal offences were recorded for each subject. Nine subjects (four non-MC, four MC, and one dual-diagnosed) had no known previous criminal convictions. Seven subjects had only two prior convictions and six subjects had only one prior conviction. All other subjects had at least three convictions.

Previous criminal conviction history was known for 41 subjects. Seventeen of 23 non-MC subjects, four of eight MC subjects, and nine of 10 dual-diagnosed

22 In one MC patient's file there was the statement that at the age of 21, the patient "allegedly tried to strangle his younger brother." There was no indication that this incident involved formal criminal charges.

subjects had previous criminal convictions. A chi-square test indicated no statistical significance for the number of convictions for the three groups of subjects.[23] Non-MC subjects had five convictions for robbery, four for impaired driving, mischief/damage to property, theft, and drug offences. MC subjects had two convictions for assault causing bodily harm/assault with a weapon, and one for other convictions. (See Table 3). Dual-diagnosed subjects had six convictions for break and enter, five convictions for robbery, and four convictions for theft.

Table 3 indicates the charges which resulted in convictions for each group of subjects. Convictions for robbery accounted for 19.2% of cases, theft for 17.3% of cases, and break and enter for 15.4% of cases. Of the 6.4% of subjects who had convictions for robbery, non-MC persons had five convictions and dual-diagnosed persons had five convictions. Convictions of theft were experienced by 5.8% of subjects--non-MC subjects had four convictions, one MC subject had one conviction, and dual-diagnosed subjects had four convictions. The next most frequent conviction was for break and enter, of which 5.1% of subjects had been previously convicted. Non-MC subjects had two convictions, and dual-diagnosed subjects had six convictions for this offence.

The least frequent number of convictions were for second degree murder, assault, disturbing the peace, escaping lawful custody, possessing stolen property, uttering, and fraud (one non-MC subject each), false alarm of fire (one MC subject), and false pretences (one dual-diagnosed subject).

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23 $X^2 = 0.3079$, $df = 2 < 5.99$ at a significance level of .05.

Table 3

Previous Convictions by Criminal Code Offence and Group

Offence	Non-MC	MC	DD
MURDER			
Second degree murder	√		
SEXUAL OFFENCES			
Sexual assault	√	√	√
Sexual assault, 16 - 18 year old	√		
ASSAULT			
Assault causing bodily harm/weapon		√	√
Assault police officer/resist arrest	√		
Minor assault	√		
OFFENSIVE WEAPON OFFENCE			
Possession of weapon or imitation		√	√
PROPERTY OFFENCES			
Arson	√		
Mischief/damage to property	√		√
False alarm of fire		√	
PUBLIC ORDER/NUISANCE			
Disturbing the peace	√		
Obstruct justice/resist peace officer	√		√
Escape lawful custody	√		
Breach of probation/bail/parole	√	√	
Breach of Young Offenders Act	√		
ROBBERY AND THEFT			
Robbery	√		√
Break and enter	√		√
Possession of stolen property	√		
Uttering	√		
False pretences			√
Fraud	√		
Theft	√	√	√
OTHER OFFENCES			
Impaired driving	√		
Narcotic Control Act offence	√		

Current charges.

The criminal charges which resulted in the patients' current remand status were recorded. Three charges were recorded for each subject, and if the patient was facing more than three charges, the three most serious were recorded.[24] Eleven non-MC subjects, four MC subjects, and five dual-diagnosed subjects had only one charge against them. Ten non-MC subjects, two MC subjects, and two dual-diagnosed subjects were facing two charges. The other nine non-MC, two MC, and seven dual-diagnosed subjects had at least three charges against them. (See Table 4.)

One non-MC subject was charged with the most serious offence (i.e., first degree murder) and another was charged with attempted murder, an offence with which he had been previously charged but not convicted. Non-MC subjects were represented in every offence category, dominating the categories of assault offences (54.05%), property offences (69.23%), and public order and nuisance offences (73.33%). Five common assault charges were attributed to only two non-MC subjects. Of the sexual offences, non-MC subjects were charged with sexual assault, indecent assault, and incest. Also, among the non-MC subjects, there were four charges of breaching a probation order. Non-MC subjects also allegedly committed all of the driving offences, including dangerous driving, failure to stop, impaired driving, driving over .08, and driving while disqualified.

MC subjects were most often charged with sexual offences and assault-related offences. For example, five assault-related offences represented 73.33% of all charges against MC accused. The most serious offence against MC subjects was sexual

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24 Appendix B (Offence/Charge Codes) lists offences in order of seriousness.

assault. The sexual assaults were not violent, and often included sexually inappropriate behaviour such as touching or fondling. There were no charges of murder, driving offences, robbery offences, or property offences against MC subjects.

Like the MC subjects, the dual-diagnosed subjects were frequently charged with sexual offences and assault-related offences (40.54% of all charges). The most serious offence committed by a dual-diagnosed accused (who had no previous criminal history) was attempted murder, following an incident on a First Nations reservation. This incident also resulted in his being charged with unlawful or forcible confinement. The most frequently laid charges against dual-diagnosed subjects were common assault and robbery, for which there were four charges for each offence. For one dual-diagnosed subject, robbery was the single charge against him. Another dual-diagnosed subject who had two previous robbery convictions was currently facing three robbery charges.

A comparison of Table 3 which summarizes previous convictions by Code offence and group and Table 4 which summarizes current Code charges for each group reveals that past and present behaviours appear consistent for each group. That is, each group of subjects had a conviction history that paralleled the current charging pattern. For example, none of the MC or dual-diagnosed subjects had been convicted of, or charged with, murder, nor were they accused of committing driving offences. Table 4 summarizes the number of Code offences attributed to the subjects in each group.

Table 4

Number of Charges by Criminal Code Offence and Group

Offence	Non-MC	MC	DD
MURDER			
First degree murder	2		
Attempted murder	1		1
SEXUAL OFFENCES			
Sexual assault	3	2	3
Indecent assault	1		1
Incest	2		
Aggravated sexual assault		1	2
ASSAULT			
Assault causing body harm/weapon	3	4	2
Aggravated assault	1	2	
Assault peace officer/resist arrest	1		
Unlawful/forcible confinement	1		3
Common assault	8	2	4
DRIVING OFFENCES			
Dangerous driving	1		
Failure to stop	1		
Impaired driving/driving over .08	3		
Driving while disqualified	1		
OFFENSIVE WEAPON OFFENCES			
Possession of weapon or imitation	1	1	
Pointing a firearm			1
Use of firearm/commission of offence			1
PROPERTY OFFENCES			
Arson	4		2
Mischief/damage to property	4		
Setting fires/damage to property	1		2
PUBLIC ORDER/NUISANCE			
Threatening/intimidation	5		
Disturbing the peace	1	1	
Obstructing/resisting peace officer	1		
Trespassing			1
Breach of probation/bail/parole	4		1
Breach of Young Offenders Act			1
ROBBERY AND THEFT			
Robbery	1		4
Attempted robbery	1		
Breaking and entering	1		
Unlawful presence			1
Possession of stolen property	3		
Fraud/fraudulently obtaining food	2		
Theft		1	

Psychiatric Assessment

Assessment orders.

A request for an assessment of the mental condition of the accused may be made at any stage of the trial by the court, the accused, or the crown attorney.[25] These assessment orders may include a request for evaluation of the existence of mental illness, fitness to stand trial, mental state at the time of the offence, and/or treatment requirements, or may request a pre-sentence report with recommendations.[26]

Requests were almost always made for more than one type of assessment (e.g., existence of mental illness and fitness to stand trial). A single assessment was requested for only six non-MC, one MC, and two dual-diagnosed subjects. Requests for assessment of the existence of mental illness, fitness to stand trial, mental state at the time of the offence, and treatment requirements were requested for six non-MC, two MC, and three dual-diagnosed subjects.

Psychiatric evaluations of the existence of mental illness were requested for 76.67% of the non-MC subjects, 75% of the MC subjects, and 64.29% of the

25 Section 672.12(2) of the Code describes the limitations on the prosecutor's application for fitness assessments: "Where the prosecutor applies for an assessment in order to determine whether the accused is unfit to stand trial for an offence that is prosecuted by way of summary conviction, the court may only order the assessment if (a) the accused raised the issue of fitness; or (b) the prosecutor satisfies the court that there are reasonable grounds to doubt that the accused is fit to stand trial." Section 672.12(3) describes the limitation on the prosecutor's application for assessment to determine whether the accused was suffering from a mental disorder at the time of the offence so as to be exempt from criminal responsibility.

26 The Code includes a form (Form 48) which specifies the purpose(s) for an assessment: to determine whether the accused is unfit to stand trial, whether s/he suffered from a mental disorder so as to be exempt from criminal responsibility (Not Criminally Responsible on account of Mental Disorder), whether s/he is a dangerous mentally disordered person, or whether, in the case of infanticide, a woman had a disturbed balance of the mind. The two other reasons for an assessment order are for the appropriate disposition of an unfit or NCRMD person, and whether a hospital order should be made.

dual-diagnosed subjects. Fitness assessments were ordered for 83.33% of the non-MC, 87.5% of the MC, and 92.86% of the dual-diagnosed subjects. Assessment of mental state at the time of the offence and treatment requirements were less frequently requested: 36.67% and 40% for non-MC subjects, 50% and 37.5% for MC subjects, and 47.86% and 50% for dual-diagnosed subjects.

Admission to F.P.I. for current remand for assessment

Over half of all subjects had no previous admissions to F.P.I. The current admission was the first one for 17 (56.67%) non-MC subjects, six (75%) MC subjects, and eight (57.14%) dual-diagnosed subjects.

Non-MC subjects spent an average of 32.2 days at F.P.I. for their assessment (median = 22, standard deviation = 39.74). The shortest stay was five days, and the longest was 208 days. The average length of stay was lowest in the Final Year, at 21.1 days.

MC subjects spent an average of 22.1 days at F.P.I. for their assessments (median = 23, standard deviation = 4.49). The range of length of admission was 14 days to 28 days, indicating little variance during the Baseline, Anticipatory, and Final Years.

The average length of remand for dual-diagnosed subjects was 31 days (median = 25, standard deviation = 27.48). The shortest admission was four days, and the longest was 119 days. The shortest length of stay was in the Final Year (27.3 days).

Figure 1

Length of Admission by Group

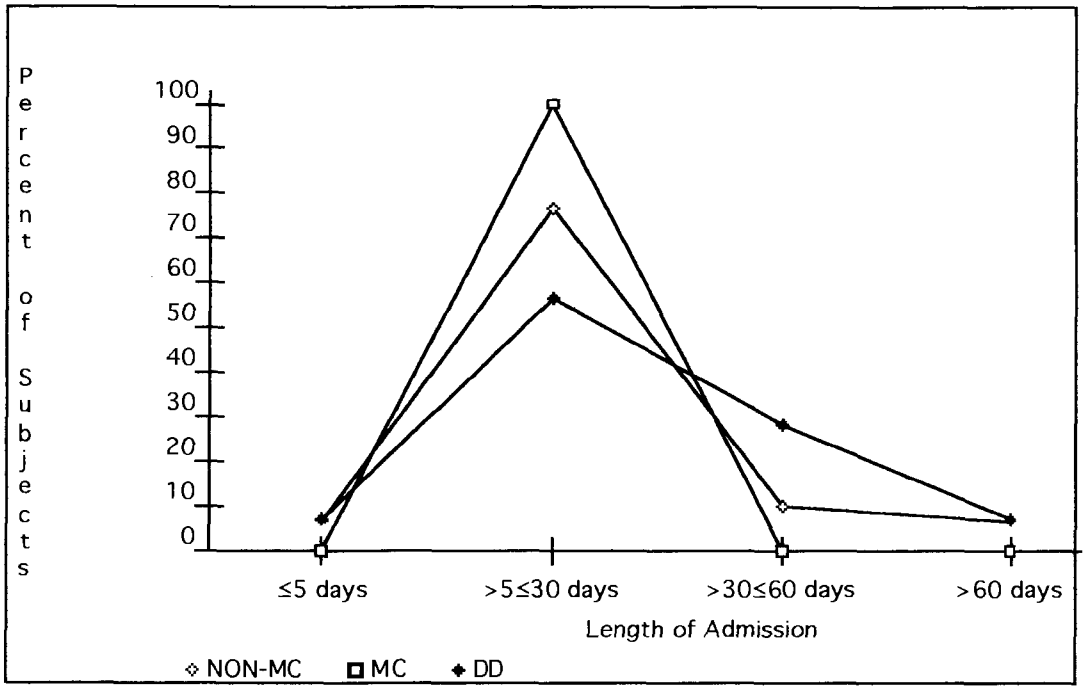

Figure 1 illustrates that the majority of all subjects, and indeed all of the MC subjects, remained at F.P.I. for five to 30 days. Analysis of variance of length of stay did not produce a statistically significant result (F=0.2855), even though the length of stay was quite long for some subjects in the non-MC and dual-diagnosed groups. Similarly, a comparison of group means using a t-test suggested that inclusion in a particular group was not a factor in the length of remand.

Psychological testing.

Thirty-four different psychological tests were administered to the subjects during their admission. (See Appendix D.) Two non-MC subjects refused to be tested.

Two dual-diagnosed subjects were considered to be untestable: One subject was unable to perform a pencil-and-paper test, and the other was illiterate.

Almost all subjects were administered at least five tests.[27] Only four non-MC subjects and one dual-diagnosed subject (excluding those who refused or were untestable) were administered less than five psychological tests.

Of the 34 psychometric tests[28] administered to the 50 subjects, the Million Clinical Multi-axial Inventory (MCMI), which is a personality inventory, was the most frequently administered test (44.2% of cases). The next most frequently used tests were the Minnesota Multiphasic Inventory (MMPI) which assesses personality, and the Wechsler Adult Intelligence Scale, Revised (WAIS-R) which tests intelligence. Both the MMPI and WAIS-R each represented 38.5% of cases. Another test of general intelligence, the Raven Standard Progressive Matrices, was used in 21.2% of cases. The next most popular tests were the Bender Visual Motor Gestalt Test and the House-Tree-Person Test (17.3% of cases) which assess intelligence and personality.

Included in F.P.I.'s armamentarium of psychological tests are instruments developed for the express purpose of assessing fitness to stand trial. While most tests were developed and evaluated in the United States (e.g., the Interdisciplinary Fitness Interview, Georgia Competency Court Test and Competency Assessment Instrument), the Fitness Interview Test (FIT) is a Canadian instrument. The FIT provides an alternative to traditional evaluations and a unique feature is a rating form for

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27 Only five tests were recorded, although the number of tests recorded was as high as eight in some cases.

28 The 34 tests administered to the subjects in this study do not represent all of the tests available at F.P.I. Over 100 psychological tests are available.

assessing the degree of impairment of common psychiatric symptoms. Although this rating form does not specifically address the issue of fitness, it offers a measure of the symptoms of a mental disorder.

One fitness test which was developed specifically for MC accused, the Competence Assessment for Standing Trial for Defendants with Mental Retardation (CAST-MR), was not used with any MC or dual-diagnosed subjects in this study despite the instrument's validity, reliability and availability.

Only one test constructed for assessing fitness to stand trial was used in this study. The Competency Screening Test (CST) consists of 22 incomplete sentences which address the trial and the defendant's relationship with her or his lawyer. The CST was administered to only three subjects--two non-MC and one MC patient. Other subjects were asked specific questions pertaining to the judicial process (e.g., What does the judge do?, What are pleas?).

Only MC subjects were administered three tests--the Benton Visual Retention Test, Luria Nebraska Neuropsychological Battery (LNNB), and Wide Range Achievement Test. The Benton and LNNB are tests that screen for brain damage. The Wide Range Achievement Test is a measurement of school achievement in the areas of reading, spelling, and arithmetic. The MCMI, which is written at an eighth grade level, was administered to only two MC and four dual-diagnosed subjects.

Table 5 summarizes the distribution of tests administered to each group of subjects. The subjects who were willing and able to be tested submitted to a total of 156 psychological tests.

Table 5

Distribution of Psychometric Tests by Group

Test	Non-MC	MC	DD
Antisocial Personality Scale	1		
Beck Depression Inventory		1	1
Beck Hopelessness Scale			1
Benton Visual Retention Test		1	
Bender Visual Motor Gestalt Test	4		5
Booklet Shortened Categories Test	2		
Carlson Psychological Survey	3		
Competency Screening Test	2	1	
Draw-A-Man Test			2
Hooper Visual Organization Test	1	1	1
House-Tree-Person Test	2	1	6
Luria Nebraska Neuropsychological Battery		1	
Memory for Symbols Test	1		
Memory for Words Test	2		
Million Clinical Multi-axial Inventory	17	2	4
Minnesota Multiphasic Inventory	16	2	2
Multiphasic Sex Inventory	2	1	
Porteus Mazes Test	1		1
Personality Disorder Questionnaire-Revised	3	1	
Raven Coloured Progressive Matrices			4
Raven Standard Progressive Matrices	8	2	1
Rey Auditory Verbal Learning Test	2	1	
Rey Complex Figure Test	1		
Rorschach Test	2		1
Shipley Hartford Retreat Scale	2		
Shipley Institute of Living Scale	3		1
Stroop Colour and Word Test			1
Thematic Apperception Test	1	1	
Trail Making Test	2		1
WAIS-Verbal Subtest	2		2
WAIS-R	11	4	5
Wide Range Achievement Test		1	
Wisconsin Card Sort Test	1		1
Word Fluency Test	2		1

DSM diagnoses.

The Diagnostic and Statistical Manual of Mental Disorders uses a multi-axial system: Axis I includes clinical syndromes and V codes[29], and Axis II includes developmental disorders and personality disorders. Mental retardation is recorded on Axis II. (See Appendix C for a summary of DSM-III-R diagnostic codes.)

Developmental disorders.

In the category of developmental disorders, mental retardation was diagnosed among 25 subjects.[30] Mild mental retardation was most frequently diagnosed (9%), followed by unspecified mental retardation (3.2%), moderate mental retardation (2.6%), and borderline intellectual functioning (2%). Diagnoses of mild mental retardation were equally distributed among MC and dual-diagnosed subjects. The two cases of borderline intellectual functioning were in the MC group.

There were five diagnoses of other developmental disorders, including conduct disorder, attention-deficit disorder with and without hyperactivity, learning disability, speech and hearing deficits, and impulse control disorder. All of these diagnoses but one (attention-deficit hyperactivity disorder) were recorded for MC and dual-diagnosed subjects.

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29 V codes are "Conditions Not Attributable to a Mental Disorder That Are a Focus of Attention or Treatment" (APA, 1987:28).

30 Two MC subjects were given two diagnoses (one mild and moderate mental retardation, and one unspecified mental retardation and borderline intellectual functioning). One dual-diagnosed subject was diagnosed with mild and moderate mental retardation (i.e., severity is between these two levels). This accounts for 25 diagnoses of mental retardation for 22 MC and dual-diagnosed subjects.

Psychoactive substance use disorders.

The first category of Axis I disorders which was diagnosed is Psychoactive Substance Use Disorders. Of the diagnoses in this category, Inhalant/PCP/ Psychoactive substance abuse was the most frequently diagnosed condition (25% of cases). This diagnosis was given to nine non-MC subjects, and four dual-diagnosed subjects. Alcohol abuse and alcohol dependence were also frequently diagnosed (also 25% of cases). There were a few cases of substance and combined substance and alcohol abuse among the non-MC and dual-diagnosed patients.

Psychotic disorders.

Among psychotic disorders, schizophrenia was frequently diagnosed. The 12 diagnoses of schizophrenia were recorded for eight non-MC and four dual-diagnosed individuals. The form of schizophrenia most frequently diagnosed was the paranoid type.

Other psychotic disorders diagnosed include delusional disorder, delusional paranoid disorder, psychotic disorder, and schizoaffective disorder. These four conditions represented 9.5% of cases. When schizophrenia is included, psychotic disorders accounted for 21% of cases.

Mood disorders.

Bipolar disorders affected only three subjects, all in the non-MC group. Depressive disorders represented 15.3% of cases. The most frequently diagnosed type of depressive disorder was dysthymia (depressive neurosis). One non-MC subject and four dual-diagnosed subjects were given this diagnosis. Other depressive disorders were given only to individuals in the non-MC group (e.g., single episode and recurrent

depression, and affective depressive disorder). Three types of anxiety disorders were diagnosed: Panic disorder, generalized anxiety disorder, and organic anxiety disorder.

Somatoform disorders.

Three non-MC subjects were diagnosed with somatoform disorders. One person had a diagnosis of somatization disorder and somatoform pain disorder.

Sexual disorders.

Five people were diagnosed with sexual disorders, specifically pedophilia and sexual disorder/paraphilia. Two non-MC subjects and one dual-diagnosed subject were considered pedophiles. MC subjects with sexual disorders were diagnosed as having non-specified paraphilia or other sexual disorders. Sexual disorders represented 9.6% of cases.

Psychological factors affecting physical condition.

DSM-III-R describes this disorder as involving a "psychologically meaningful environmental stimuli" that is temporally related to a specific physical condition or disorder which involves either "demonstrable organic pathology (e.g., rheumatoid arthritis) or a known pathophysiologic process (e.g., migraine headache)" (p. 187). The non-MC subject who was diagnosed with this condition was also diagnosed with a delusional disorder and a paranoid personality disorder. The clinician indicated that this person required physical treatment, and also required a CAT scan.

Personality disorders.

Personality disorders were also popular diagnoses (55.7% of cases). Almost two-thirds of non-MC subjects, one-fourth of MC subjects, and over half of dual-diagnosed subjects were diagnosed with a personality disorder. Personality disorders

with mixed features was the most frequently diagnosed type of personality disorder, especially among non-MC subjects.[31]

No disorder or diagnosis.

Up to three diagnoses on each axis were recorded for each subject. Non-MC subjects had a total of 68 diagnoses plus three deferred diagnoses. MC subjects had 16 diagnoses. Dual-diagnosed subjects had 46 diagnoses plus two deferred diagnoses.

None of the non-MC subjects had more than four diagnoses.[32] Eight subjects had only one diagnosis, eight subjects had two diagnoses, nine subjects had three diagnoses, and five subjects had four diagnoses. The average number of diagnoses for each non-MC patient was 2.4.

None of the MC subjects had more than three diagnoses because a condition of inclusion in this group was absence of a clinical syndrome (i.e., Axis I disorder). Three subjects had only one diagnosis, and three subjects had three diagnoses. Of the three groups, MC subjects had the lowest average number of diagnoses per person (two diagnoses) because they were not diagnosed with an Axis I disorder.

The minimum number of diagnoses for dual-diagnosed subjects was two. Dual-diagnosed subjects had the highest average number of diagnoses per person--3.4 diagnoses. Four subjects received only two diagnoses. One subject received six diagnoses, the highest number of diagnoses for this group.

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31 This diagnosis (301.89) is not listed in DSM-III-R. The files that included this diagnosis number recorded it as "Personality disorder with mixed features."

32 For the purposes of this summary, a deferred diagnosis was counted as a diagnosis.

Table 6

Summary of Diagnoses by Group

Type of Disorder	Non-MC	MC	DD
Mental Retardation	0	10	15
Disruptive Behaviour	1	1	1
Other Disorders of Infancy, Childhood or Adolescence	0	0	2
Impulse Control	1	0	0
Speech and Hearing Deficits	0	1	0
Psychoactive Substance Use	20	0	9
Schizophrenia	8	0	4
Delusional	2	0	1
Psychotic Not Elsewhere Classified	2	0	0
Bipolar	3	0	0
Depressive	5	0	3
Anxiety	1	0	2
Somatoform	3	0	0
Sexual	2	2	1
Psychological Factors Affecting Physical Condition	1	0	0
Personality	19	2	8

Clinical impressions.

Nurses made notes concerning patients on the wards for every shift. These impressions were coded and a maximum of four observations were recorded for each subject. In some instances, impressions were consistent (e.g., the patient was

cooperative with staff), and this was, therefore, the only impression recorded. In other cases, a patient's behaviour would vary from one shift or day to another, resulting in sometimes conflicting observations (e.g., the patient was cooperative with staff, and the patient was uncooperative with staff and clinicians performing testing).

Non-MC subjects had an average of 1.9 recorded impressions, and MC subjects and dual-diagnosed subjects had an average of 2.6 recorded observations. Length of admission was not a factor in the number of recorded impressions since these observations were made over a period of at least five days, which was the minimum length of admission for these subjects.

Based on nurses' impressions, the majority of non-MC subjects were often cooperative; however, there were nine instances of uncooperative behaviour (e.g., the patient refused to consent to treatment and/or medical investigation), and nine observations of poor or hostile relations with patients and staff. For example, one patient presented herself as a nurse to her co-patients and offered advice regarding their treatment, and as a result, the staff had to spend extra time explaining and justifying treatments to these patients. Non-MC subjects rarely exhibited unpredictable behavior or approval-seeking behaviour. They were more likely than MC subjects to refuse to provide information requested by staff or clinicians.

MC subjects were regularly viewed as cooperative, vulnerable, approval-seeking, and eager to please staff and others. For instance, one patient was frequently "redirected to stop hanging around the office" and was described as "friendly (overly)". One subject with a speech and hearing deficit was unable to provide information requested by staff. Aggressive behaviour toward staff and others was

observed in only one MC subject. There were no recordings of poor or hostile relationships with other patients and staff.

Similar to the non-MC and MC groups, subjects in the dual-diagnosed group were often described as cooperative with staff. Six dual-diagnosed subjects were observed as unwilling or unable to provide information requested by staff. One subject was described as a "poor historian", and another patient's answers were suspect because of his eagerness to please the interviewer (i.e., give the "correct" answer). Of the two subjects for whom there were recorded observations of poor relations with staff and others, one was described as "asocial" and the other suffered from paranoia which resulted in improper reaction to environmental cues. Dual-diagnosed subjects had more recorded observations of exhibiting unpredictable behaviour than subjects in the non-MC and MC groups.

Letter to court and discharge status.

Clinicians indicated in their letters to the court that seven non-MC subjects would be considered fit after treatment of their conditions; however, treatment was not a factor for the fitness of MC or dual-diagnosed subjects. F.P.I. was described as inappropriate for one non-MC subject, two MC subjects, and one dual-diagnosed subject. One clinician wrote that F.P.I. was not "oriented to the care of the mentally handicapped." The dual-diagnosed subject was directed to a mental hospital for senior citizens.

Special consideration during the trial was suggested for two MC and one dual-diagnosed subject. Clinicians wrote that both MC subjects would require patient and sympathetic defence counsel, and one MC subject, who had a speech and hearing disability, would require an interpreter to get through the trial. The dual-diagnosed

subject was considered fit, but the clinician wrote that the patient "would not be able to follow extremely sophisticated language for any length of time."

Table 7

Fitness Decisions by Group[33]

Discharge Status	Non-MC	MC	DD
Fit to stand trial	24	7	5
Unfit to stand trial	2	1	5

Admissions for three non-MC subjects and one dual-diagnosed subject were changed to involuntary (i.e., committed under the provincial Mental Health Act). Charges were dropped against one subject in the dual-diagnosed group, and another subject was found not criminally responsible on account of mental disorder. Discharge status was unfit to stand trial for two non-MC, one MC, and five dual-diagnosed subjects.

Treatment recommendations.[34]

Up to four treatments recommended by clinicians were recorded for each subject. Almost half (46.2%) of the subjects received multiple recommendations.

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33 Computation of X^2 using values in this table yields a statistically significant result (X^2=8.903, $p<.05$; with Yate's Correction, X^2=6.110, $p<.05$). However, expected values in two cells are lower than five (Non-MC=4.727, MC=1.455), thus affecting the certainty of the result that one group is more likely than the others to be found fit or unfit to stand trial.

34 Treatment recommendations were the conditions that the clinician believed would benefit the patient, considering her or his diagnosis. It has been argued (e.g., Steinbock, 1976) that treatment recommendations form part of of the diagnostic process.

The most frequently recommended treatment of the treatments available was individual or group therapy (44.2%), followed by medication (32.7%), and supervision or group home residency (26.9%). Community outpatient care was recommended for only seven subjects and Forensic Psychiatric Services outpatient care was recommended for four subjects.

Therapy and medication were the two most often recommended treatments for non-MC subjects. Other recommendations were treatment for physical health (two subjects), and participation in a residential alcohol treatment program.

Supervision and group home residency were recommended for six (75%) MC subjects. Medication and therapy were the other two suggested treatments.

Treatments recommended for dual-diagnosed subjects included individual therapy (50%), supervision or group home residency (42.9%), medication (28.6%), and community outpatient care (14.3%). Other recommendations included long-term inpatient care, residence in a mentally handicapped senior citizens' facility, participation in a sex offender treatment program, and further F.P.I. care under supervision of the review board. One subject was referred to services for MC persons in another area. Definite recommendations were not made for two subjects--one was remanded for further observation, and charges against another subject were dropped, thereby negating the need for treatment suggestions.

Summary

Non-MC group.

A review of the files of 30 non-MC subjects remanded to F.P.I. revealed that the majority of patients were unemployed, non-native males with an average age of 37 years. Over half of the subjects in this group had previously been admitted to a mental

health institution. Two-thirds of these admissions were for periods of less than 30 days. Intelligence quotients were reported for almost two-thirds of the group--13 subjects had average to above average IQs, and five subjects tested in the borderline mental retardation range.

Almost 90% of non-MC subjects had previously been charged with a Code offence, and 74% had previous criminal convictions. Convictions were for a variety of Code offences, including murder, assault, theft, and driving offences. Non-MC subjects were remanded for the most serious of offences (i.e., first degree murder), and were the only subjects charged with driving offences.

Non-MC subjects spent an average of 32.2 days at F.P.I. for their assessments, during which time all but two subjects participated in a battery of psychometric testing. The two most frequently diagnosed disorders among the non-MC subjects were psychoactive substance use disorders and personality disorders.

During their stay at F.P.I., most of the subjects were considered cooperative, although there were some observations of uncooperative behaviour and poor or hostile relations with staff and other patients. The discharge status for 80% of non-MC subjects was fit to stand trial. Therapy and medication were the most frequently recommended treatments.

MC group.

The files of eight MC patients were reviewed during the three study years. MC subjects were significantly younger than subjects in the non-MC and dual-diagnosed groups. All MC subjects were non-native and all subjects but one were male. All subjects were unemployed, but two indicated they were employed part-time or occasionally.

All MC subjects had previous admissions to mental health institutions. Over half of the admissions were for periods longer than 60 days. Intelligence quotients were reported for seven subjects; of these, six subjects scored in the borderline mental retardation to mild mental retardation range.

Half of the MC subjects had been previously charged with criminal offences, and had convictions for sexual, assault, weapons, property, and theft offences. There were no convictions for driving or narcotics offences. Charges resulting in the current remand status were for sexual offences and assault-related offences.

The current admission was the first for six MC subjects, and the average length of admission was 22.1 days. All subjects were admitted for periods of between five and 30 days. Subjects submitted to 15 different psychometric tests, and half were administered the WAIS-R intelligence test. Five types of disorders were diagnosed among MC subjects: Mental retardation, disruptive behaviour, speech and hearing deficits, sexual disorders, and personality disorders. Nurses generally viewed MC subjects as cooperative, vulnerable, approval-seeking, and eager to please others. Seven subjects were discharged as fit to stand trial, and one was recommended as being unfit to stand trial. Supervision or group home residency was recommended for six of the eight MC subjects. Individual therapy and medication were each recommended for three subjects.

Dual-diagnosed group.

The dual-diagnosed group was comprised of 13 males and one female. Eight subjects were native and six were non-native. Eleven subjects were unemployed, and one subject indicated that he had a full-time job. The average age at the time of remand was 33 years.

Only one subject did not have a previous admission to a mental health institution. There were 23 admissions among 11 subjects. Half of the subjects tested in the IQ range for mild mental retardation. Low levels of functioning prevented two subjects from being tested successfully.

One subject had no previous criminal charges against him. The most serious conviction for dual-diagnosed subjects was sexual assault. There were no convictions for driving or narcotics offences. Almost half of the current charges were sexual assault and assault-related. The most serious charge was attempted murder.

Dual-diagnosed subjects spent an average of 31 days at F.P.I. During this time, 19 different tests were administered. The WAIS-R and House-Tree-Person tests were the most frequently administered instruments. The most frequent diagnoses were mental retardation, psychoactive substance use disorders, and personality disorders. During their admission, subjects were often considered to be cooperative, although there were also observations of unpredictable behaviour.

Discharge status was fit to stand trial for five subjects, and unfit to stand trial for five subjects. Charges were dropped against one subject. Therapy was the most frequently recommended treatment for dual-diagnosed subjects, followed by supervision or group home residency and medication. Two subjects were referred to other facilities or agencies.

Chapter Six

Discussion

Sociodemographic Characteristics

Gender.

The finding that most of the subjects in this study were male is consistent with several other studies of defendants who were referred for psychiatric assessments. First, a review of 28 studies comparing incompetent and competent defendants revealed that the average percentage of males involved in the studies was 89.5% (Nicholson & Kugler, 1991:358). Second, of 73 MC defendants referred for competence assessments in a Michigan study, 94% were male (Thompson & Boersma, 1988:9). Research involving MC defendants evaluated for fitness to stand trial in Ohio found that 97% were male (Everington & Dunn, 1992:6). More recent research investigating MC offenders in British Columbia found that 91% of all patients admitted to F.P.I. between 1977 and 1992 were male (Coles, Veiel, Tweed, Johnson & Jackson, 1993:14), and of 175 patients diagnosed with mental retardation, 75% were male (Veiel, Coles, Tweed, Johnson & Jackson, 1993:18).

The increased prevalence of mental retardation among males as documented in the literature has been consistent. For example, of 107 admissions for psychiatric examinations between 1965 and 1966, 16 men were diagnosed with mental retardation (Binns, Carlisle, Nimmo, Park & Todd, 1969a:1127). In another study during the same period, 18 of 83 remanded subjects were diagnosed with mental retardation--13 were men and only five were women (Binns, Carlisle, Nimmo, Park & Todd, 1969b:1135). More recently, the ratio of the prevalence of mental

retardation between men and women has been reported as ranging from 1.27 to 1 (McDonald, 1973) to 1.37 to 1 (Lindsey & Russell, 1981). Veiel et al. (1993) suggest that differential labelling practices may account for the larger number of males being diagnosed with a mental handicap because their maladaptive behaviours may be more observable.

There does not appear to be a significant relationship between gender and fitness to stand trial. Admittedly, the number of females in this study was quite small; however, other studies affirm this finding (Reich & Wells, 1985; Roesch et al., 1981). A study conducted at the Metropolitan Toronto Forensic Service found that "differences on the basis of sex approached significance with females more likely to be found unfit" (Rogers, Gillis, McMain & Dickens, 1990:531).

Age.

The MC subjects in this study were somewhat younger than subjects in several other studies, but one study reported a similar finding: Pierrel (1985:54) reported a mean age of 26.7 for 73 subjects diagnosed with mental retardation who were referred for competency assessments. Another study reported a mean age of 30.67 for MC defendants who were recommended as competent to stand trial, and 28.22 for MC defendants who were recommended as incompetent to stand trial (Everington & Dunn, 1992:6). An earlier study (MacEachron, 1979:167) reported a much higher average age--33.54 for "retarded offenders". Others did not find any significant age differences among non-MC and MC groups (Thompson & Boersma, 1988).

Although the findings are inconsistent and do not reveal a definitive age pattern, the differences in age averages (approximately four years) reported in the various studies is slight. A Swedish study, however, offers an explanation for any tendency

that persons with mental retardation come to the attention of the justice system at an earlier age than non-impaired persons: Hodgins (1992:478) reported that for intellectually impaired male subjects, the proportion of subjects beginning their criminal careers decreased after the age of 18 years, and for intellectually impaired females, increased criminal activity occurred between the ages of 18 and 21 years. A much larger sample is needed to determine if there exists a regional or national age pattern in MC persons accused of criminal behaviour.

Race.

The relationship between race and criminality or race and intelligence is both controversial and difficult to study (Veiel et al., 1993). In the United States, it has been reported that a large percentage of offenders with mental retardation are "nonwhite" (Noble & Conley, 1992), especially Afro-Americans and Latinos (McGee & Menolascino, 1992). Based on prison populations,[35] the percentage of Caucasian inmates with WAIS-R IQ scores below 70 has been reported to be as low as 5% in New York (Sundram, 1989), but a community program in Pennsylvania indicated that 91% of its clients were Caucasian (White & Wood, 1986:83).[36] In Canada, a combination of discrimination and actual criminal behaviour has been cited as responsible for an over-representation of Native people in the criminal justice system (Griffiths & Verdun-Jones, 1994:640).

35 Endicott (1991:12) reminds that "the administration of psychometric tests in the environment of a penal institution requires exceptional skill, if the results are to be treated as having both usefulness and reliability. These skills must include knowledge of the forensic sciences and sensitivity to the impact on the prisoner of the physical and social environment."

36 Noble & Conley (1992:41) state that "the high percentage of incarcerated offenders with mental retardation who are nonwhite results from the combination of above-average rates of incarceration for nonwhite Americans and an above-average percentage who test in the range for mental retardation."

In a study involving 11 of 12 state-wide clinics of the Association of Ohio Forensic Psychiatric Centers, a group of 15 MC defendants who were recommended as being competent to stand trial was comprised of 80% Caucasian and 20% Afro-American defendants; and, a group of 20 MC defendants who were recommended as being incompetent to stand trial was comprised of 59% Caucasian and 41% Afro-American defendants (Everington & Luckasson, 1992b:31-33). Most studies have found no relationship between race and competency to stand trial (Daniel et al., 1985; Reich & Wells, 1985), although one study found that defendants judged incompetent to stand trial were more likely to be Black (Johnson, Nicholson & Service, 1990), and another study found that patients who were judged questionably fit or unfit to stand trial were significantly more likely to be non-white (Rogers et al., 1990).

Of all patients remanded to F.P.I. for assessments between 1977 and 1992, 8.4% were Native (Coles et al., 1993:14), although the percentage of the total Native population in British Columbia has been cited at only 3% (Griffiths & Verdun-Jones, 1994:632). A study conducted in the Brief Assessment Unit of the Metropolitan Toronto Forensic Service in 1978 indicated that 88.7% of pre-trial forensic patients were Caucasian, 7.5% were Black, and 1.9% were North American Indian (Menzies, 1989:34).[37] This compilation shows that pre-trial forensic patients in British Columbia and Toronto, at least, are mostly Caucasian, and in British Columbia, Natives apparently are over-represented in the forensic services.

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37 (Griffiths & Verdun-Jones, 1994:632) report that the percentage population of Natives in the province of Ontario is 1.3%, but they do not report the percentage of Natives living in the metropolitan Toronto area.

In the present study, all four Native non-MC subjects and three Native dual-diagnosed subjects were recommended fit to stand trial, three Native dual-diagnosed subjects were recommended unfit to stand trial, and two Native, dual-diagnosed subjects received other recommendations.

Psychiatric History

Previous admission to mental health institutions.

While some research indicates that defendants with a history of previous admissions to mental health institutions were more likely to be judged incompetent to stand trial (e.g., Nicholson & Kugler, 1991), this study did not support this finding. Only two non-MC subjects and three dual-diagnosed subjects who had previous mental health institution admissions had a discharge status of unfit to stand trial.

The question of readmissions must be addressed, as 21 patients who were admitted for psychiatric evaluations in the current study had been residents at F.P.I. on at least one previous occasion. The increasing rate of readmissions of MC persons to F.P.I. has already been documented. Sasaki and his colleagues (1990:7) reported that:

> ... the number of readmissions to F.P.I. has significantly increased during [1985 - 1989]. ... [In] 1988 and 1989, nine out of 14, and eight out of 14 cases respectively were readmitted to the Forensic Psychiatric Institute for treatment purposes. These patients readmitted to the Institute were returned as unfit to stand trial or not guilty by reason of insanity; through temporary absence; or held for involuntary treatment under the Mental Health Act following the withdrawal of criminal charges or the issuance of a stay of proceedings.

Reduced community tolerance for criminal behaviour and over-crowding in correctional institutions have been cited elsewhere as reasons for increased utilization

of beds in mental health facilities (Melick, Steadman & Cocozza, 1979).[38] The "criminalization" of mental disorders and mental handicaps (Davis, 1992; Teplin, 1983; Teplin, 1984), and the "medicalization" of criminal behaviour (Melick et al., 1979) have resulted in an increased proportion of MC individuals in forensic populations (Coles et al., 1993). Furthermore, it has been suggested that a diagnosis of mental retardation is related to the length of hospitalization because if MC patients do not retain legal counsel for review board hearings, they are forced to rely on their own impaired ability to articulate their case and persuade the board that they are prepared for release (Harris, Rice & Cormier, 1991). Finally, the practice of deinstitutionalization, and the lack of community resources for released patients have also been cited as reasons for the increased number of MC persons being admitted to forensic psychiatric facilities and the shorter period between readmissions (Sasaki et al., 1990).

The discretion of the police and the courts is another factor which may affect the diversion of mentally disordered and mentally challenged persons from the justice system to the mental health system (Melick et al., 1979). For example, Gingell (1991) suggested that decision-making biases by police, courts, and other criminal justice system personnel are partially responsible for the transfer of individuals from one system to the other.

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38 This problem is very complex and involves intertwined issues such as "psychiatry and social control, the use of institutions, informed consent, personal autonomy, the relationship between public perception and social reality, the many levels of 'competency', the role of free will in the criminal law system, the limits of confidentiality, the protection duty of mental health professionals, the role of power in forensic evaluations" (Perlin & Dorfman, 1993:65). These factors all affect the "place" of mental disability in legal practice (the criminalization of mental disabilities), and mental health practice (the medicalization of criminal behaviour).

The lack of data on the rates of identification of mental disability among arrestees makes it impossible to determine what percentage of individuals with mental retardation is diverted to the mental health system (Petrella, 1992). Thus, the combination of low visibility of diversionary and discretionary decision-making, and the combined processes of deinstitutionalization, criminalization, and medicalization make the significance of previous institutionalization unclear.

Intelligence quotient.

The intelligence quotient (IQ) is a measure of the rate of intellectual development (Zigler, Balla & Hodapp, 1984). One of the criteria for a diagnosis of mental retardation is an IQ of 70 or lower on a standardized test designed to measure general intellectual functioning.[39] Additional considerations must be acknowledged in any discussion of the reporting of IQ scores. For instance, different standardized intelligence tests may result in the same person achieving different IQ scores; IQ tests have standard errors of measurement; IQ tests may be culturally or linguistically inappropriate for some individuals; and a low IQ score alone does not warrant a diagnosis of mental retardation (Lemeshow, 1982; Zigler et al., 1984). Moreover, IQ is only one factor in the determination of which patients are indeed mentally challenged. For example, a recent study on mentally challenged patients at F.P.I. included patients with IQs of less than 70 ("mentally handicapped") as well as

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39 In DSM-III-R, the American Psychiatric Association (1987:28) notes that, "Since any measurement is fallible, an IQ score is generally thought to involve an error of measurement of approximately five points; hence, an IQ of 70 is considered to represent a band or zone of 65 to 75." Remember, also, that "no individual can be labeled retarded unless he or she displays a deficit in adaptive behavior" (Zigler et al., 1984:226).

"functionally handicapped" patients who had lower levels of functioning and intellectual impairment but were not "mentally retarded" (Sasaki & Nelson, 1991).

A co-existing mental disorder may also distort the "true" level of cognitive functioning. In one case in this study, the clinician wrote of a non-MC patient who scored in the range of borderline mental retardation:

> Cognitive assessment utilizing the WAIS-R revealed a profile with a wide variation between subtests. Vocabulary scored the highest, whereas mathematical ability and visuo-motor skills scored lowest. As is usually the case with a depressive condition, the Performance Scale generally yields a lower score than the Verbal Scale. ... This is viewed as representative of current cognitive functioning, but not necessarily of the premorbid IQ.

The finding that competent defendants have higher IQs than incompetent defendants has been reported in studies conducted in the United States. For example, Johnson et al. (1990) reported that defendants judged competent to stand trial had significantly higher IQs than incompetent defendants. Also, a review of eight studies of criminal defendants revealed a statistically significant negative correlation between defendants' IQ and their competency status, indicating that incompetent defendants scored lower on standardized intelligence tests than competent defendants (Nicholson & Kugler, 1991).

This trend is evident in studies of criminal defendants with mental retardation. Everington and Dunn (1992:6) reported that a group of defendants diagnosed with mental retardation who were recommended as being competent to stand trial had a mean IQ of 65.67, while a group of defendants diagnosed with mental retardation who were recommended as being incompetent to stand trial had a mean IQ of 56.20. In an Ohio study, an average IQ of approximately 59 was reported for competent MC defendants and an average IQ of approximately 58 was reported for incompetent MC defendants (Everington & Luckasson, 1992b:31-33). In a study conducted in Louisiana, of 21

subjects who were unlikely to gain competency, 10 had moderate mental retardation (IQ range of 35 to 49), and seven had severe mental retardation or below (Pierrel, 1985:54).

Of the six patients with mental retardation who had a discharge status of unfit to stand trial in this study, two patients were diagnosed with mild mental retardation (IQ range of 50 to 70), and two patients were diagnosed with moderate mental retardation.

The meaning of an IQ of 80, which is in the range of borderline mental retardation, in relation to knowledge of the offence and the criminal justice procedures was explained in one patient's case:

> This means that he is generally capable of appreciating the significance of his conduct and it's [sic] relationship to the law in general terms, but that his judgment of appropriate behaviour in certain situations may not be as good as that of most people.

Maloney (1985) stated that defendants with mild mental retardation have the potential for fitness to stand trial because they can usually be taught the functions of counsel, crown attorney, and the criminal trial proceedings. For example, in this study, one clinician described how a patient who scored in the range of mild mental retardation understood the legal process:

> Surprisingly, he knows his charge, knows where his court is being held, and states that he has not entered a plea but plans to enter a plea of not guilty. He knows that a judge's role is to "find out if I'm guilty or not guilty by discussing the case." He knows, with respect to the lawyers, that "one takes my side and one takes the other side."

For other defendants, intelligence may be an immutable factor in relation to their fitness to stand trial, but yet present a dilemma for both the mental health and criminal justice systems, especially if the pending trial involves serious charges or threats to public safety. For one subject in this study, the level of intelligence

resulted in a recommendation of unfitness to stand trial, but outstanding charges of a serious offence could not be ignored:

> Assessment of intelligence and problem solving via pictorial means yields a level below that of a three year old infant. While it is of course difficult to make comparisons in functioning between a healthy infant of that age and a dysfunctional male of 66 years of age, the comparison is still viewed as worthwhile.

The clinician noted further:

> Although [the patient] has again been duly certified under the Mental Health Act, in view of his history and the circumstances of outstanding charges of bank robberies, understandably enough the Crown is unwilling to enter a stay of proceedings any longer.

Thus, it is apparent that the level of intelligence has continued to be a factor in the issue of fitness to stand trial. The emphasis on intelligence was explained by Lewis (1949:101) who wrote that "it is possible to make fairly accurate measurement of an individual's intelligence and of his special intellectual capacities." Decades later, the issue of intelligence was again asserted as "quite important" for defendants with mental retardation, and that "the situation becomes increasingly critical as the level of intelligence decreases" (Maloney, 1985:48). While the intelligence variable is important in the fitness issue, there are other factors, such as public safety, that also affect prosecutorial discretion.

Criminal History

It has been argued that "it makes good sense to implicate low intelligence in criminality" because people with high IQs "have a better chance to succeed in their educational endeavors, to achieve middle-class status, and to enter professions and jobs carrying social approval and reasonably high rates of financial reward" whereas those with lower IQs turn to crime in order to gain affluence (Eysenck & Gudjonsson,

1989:50).[40] It follows, then, these authors argue, that the types of crimes committed by mentally challenged individuals include those which do not require the offender to have a high level of intellectual functioning, such as mugging or burglary as opposed to corporate crimes or elaborate fraud schemes (Id.).[41]

Of course, social, economic and environmental factors are also important. When discussing a convicted murderer with IQ scores of 64 and 69, Boyd (1988:278) stated that, "We can be just as accurate, insofar as the dictates of science are concerned, in claiming that Mickey Feener was 'strange', a young man with minimal verbal and mathematical skills, rejected by his parents and raised by the state." Moreover, research conducted by the Office of the Public Advocate in Australia found that "offenders with an intellectual disability showed a pattern of recidivism of minor offences, and their involvement with the criminal justice system was the final stage in a history of 'difficult' behaviour within institutional or community facilities" (Goldhar, 1989:856). It can also be argued that previous convictions and incarceration affect further criminal acts by MC persons. One study reported that 88% of MC individuals were reconvicted of an offence within two years of their release (Sapsford & Fairhead, 1980).

Another explanation for the types of criminal activities usually associated with MC individuals was stated by a clinician in his discussion of an accused male patient

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40 Interestingly, one MC subject in this study previously convicted of robbery and currently remanded for robbery did not commit the offence to gain affluence, as it was noted that he often gave away the proceeds from his crimes.

41 It must be noted, however, that "[one] can never know with certainty how many crimes are committed by people with mental retardation, since, with rare and unimportant exceptions, the guilty person must be apprehended to determine whether mental retardation is implicated. Many crimes go unsolved" (Noble & Conley, 1992:18).

who was diagnosed with mental retardation and was remanded on assault-related charges:

> Individuals with low intelligence, or brain damage, or both often do have problems with impulse control. Over time, basic deficits evolve into specific patterns of behaviour which may or may not be responsive to environmental manipulation.

In a review of persons referred to the New York State Office of Mental Retardation and Developmental Disabilities Bureau of Forensic Services, it was reported that 35.9% of charges were for crimes against the person, 22.2% were sex-related, 20.3% were for crimes against property, and 11.1% were arson (Exum, Turnbull, Martin & Finn, 1992:11). A Swedish study reported that more intellectually handicapped men than non-impaired and mentally disordered men committed violent offences,[42] thefts, and traffic offences (Hodgins, 1992:479).

Veiel et al. (1993:20) reported that, in the period from 1977 to 1992, homicide was the least frequent charge laid against mentally handicapped patients at F.P.I., and that almost twice as many non-handicapped patients were charged with homicide than handicapped patients (9.2% and 5%). In contrast, mentally handicapped patients were more often charged with assault-related offences, non-violent sexual offences, and arson and related offences (Id.).

One patient with mild mental retardation in this study was charged with the sexual assault of a 12-year-old child. In his report, the psychiatrist offered an explanation for the patient's sexually inappropriate actions:

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42 Violent offences were defined as those offences "involving the use or threat of physical violence (for example, assault, rape, robbery, unlawful threat, and molestation)" (Hodgins, 1992:478).

> I am inclined to believe that the patient is not a sexual offender of the predatory type but rather his sexually inappropriate behaviour is impulsive and poorly thought out and is a reflection of his limited intellectual functions, limited social skills, and lack of insight into his difficulties.

Two other patients (one with unspecified mental retardation and one with mild mental retardation) were charged with non-violent sexual offences and, in each case, the clinician's report implicated poor socialization and low intellectual functioning in the patient's sexually inappropriate behaviour:

> This person shows evidence of limited intellect, personality impairment, particularly in the area of relationships with others and also immature sexuality with impaired judgment regarding the perceptions and reactions of others to his own nudity or sexual behaviour.

For the patient with a history of sexual assault charges and convictions, the psychiatrist wrote that the patient was "poorly socialized and chooses children as non-threatening companions."

Reaction of the criminal justice system.

There appears to be a shift in attitudes towards the handling of MC individuals accused of committing criminal offences. Just ten years ago, there was the view that MC individuals suspected or convicted of criminal behaviour should be "locked up", despite the practice of deinstitutionalization. For example, a letter dated 1983 from Mental Health Resources was included in a patient's file in which the writer stated that:

> Probation staff, judges, and police have placed a great deal of pressure on Mental Health Resources' institutional managers to lock up a mildly or even moderately retarded person rather than let the person face the court process. Or, even after holding trial, the judge wants the person locked up in a non-prison like Woodlands, Glendale, or Tranquille where he will be safe from "brighter" prisoners.

More recently, however, diversion from the criminal justice system is being recognized as an alternative for mentally disordered or mentally challenged accused

persons. For example, in 1992, inter-ministry protocols for the management of persons with a mental disorder or a "mental handicap" who come into conflict with the criminal justice system in British Columbia were developed, and among the guiding principles believed important in the management of mentally impaired individuals are the following:

> *The Diversion of criminal charges for persons with a mental disorder or mental handicap is to be undertaken by Crown Counsel wherever it is deemed appropriate.
>
> *Sensitivity to the particular problems and needs of persons with a mental disorder or mental handicap at all "key junctures" in the criminal justice process should be actively encouraged (Committee on the Effects of Deinstitutionalization on the Criminal Justice System, 1992:3-4).

While the protocols represent an increased recognition of the special problems mentally disordered and mentally challenged persons experience in the justice system, there are other factors that would affect the appropriateness of diversion. First, protection of the public and community concerns about the real or perceived increase in national and local crime rates[43] may increase the pressure on police to lay charges against all suspects and on Crown Counsel to actively prosecute persons accused of criminal behaviour. Other explanations include amended enforcement strategies to improve police agencies' catch rate, an increase in the number of people in the "high crime risk" age group, and an increased level of citizen's reporting of crime, especially for certain offences such as sexual assault (Griffiths & Verdun-Jones, 1994:17).

Furthermore, discretionary practices of the police and Crown counsel with respect to mentally disordered or mentally challenged accused persons are limited by

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43 An increase in crime rates does not necessarily mean that there is an increase in criminal activity (Griffiths & Verdun-Jones, 1994:17).

the view of the criminal justice system as being "in crisis." It has been argued that Canadian citizens and Canadian justice have been betrayed at all points and by all players in the justice system, and it has been implied that the current crisis situation of the criminal justice system warrants increased measures to protect non-criminal citizens from accused persons and offenders:

> Our judges don't see, and to my mind, don't care, how their legal games affect the street; the shrinks are still going around and around in ever-diminishing circles; the corrections people are out of control; social workers are all over the justice system like a plague of missionaries; the Young Offenders Act is still creating gang violence and feeding new talent into the criminal mainstream. Lawyers are playing asinine games with the Charter. And our rulers, soft and well-insulated from the street, are entertaining themselves with delusive constitutional games because that's so much more fun than attending to the real problems of this country (Stroud, 1993:1)

Thus, increased public pressure to apprehend suspected offenders, especially those who are suspected of committing sex-related crimes, appears to run in a different direction from the inter-ministerial protocols which suggest that diversion may be appropriate for mentally disordered or mentally challenged individuals in some cases. Those who agree with the views espoused by Stroud (1993) will have an indirect voice in dictating which accused individuals are to be diverted from the criminal justice system.

Psychiatric Assessment

Forensic services have a critical role in the handling of individuals with mental disabilities who are involved in the criminal justice system (Petrella, 1992; Rogers & Mitchell, 1991). The remand period permits a variety of psychiatric activities which furnish the court with clinical information about people charged with criminal behaviour: collection of evidence for the trial of the issue of fitness; diagnoses and assessments of disorders and behaviour; education in the procedures of the court and

basic legal concepts, such as meaning of the oath and the meaning of pleas; and the substance and legal significance of the offence (Menzies, 1991; Ryan, 1992).

Although the main focus of forensic services is on individuals with mental disorders, and not mental retardation (Petrella, 1992), "the psychiatrist in mental handicap has a role to play in forensic psychiatry and to be therapeutically successful he and the clinical team must individually and collectively practise their professional skills at the highest levels" (Hunter, 1979:145). Unfortunately, the long-standing focus on mental disorder suggests that forensic psychiatrists who specialize in mental retardation are a rare breed, and raises the question about the accuracy of diagnoses (Coles et al., 1993).

The importance of accurate pretrial screening of individuals with mental retardation has been documented: 67% of accused persons with mental retardation confess at the time of arrest and 51% plead guilty to the original charge (Chellson, 1986). To increase the accuracy of diagnoses and assessments of defendants with mental retardation, it has been suggested that the Code section dealing with assessment orders be amended so that pre-trial evaluations are made "by any person qualified with respect to the particular mental disorder in question" (Raetzen, 1977:125). This would require that an evaluation of an MC defendant be conducted by a person familiar with the symptoms and nuances of mental retardation.

The possibility of gaining experience with MC defendants referred for psychiatric evaluations may be hampered by the high turnover rate of psychiatric staff at F.P.I. For example, in this study, of the 12 psychiatrists who conducted assessments, only one psychiatrist conducted assessments during each of the three study years, and four psychiatrists conducted assessments in two of the study years.

Similarly, in their 15-year review, Coles and his colleagues (1993:22) noted that, "there was a considerable turnover of diagnosing psychiatrists."[44] Although the psychiatric staff changed considerably, the forensic psychiatric issue did not--psychiatrists, regardless of their background, were still required to describe how a patient's mental illness affected the patient's ability to form intent, to assume criminal responsibility for his or her behaviour, or to be fit to stand trial (Menzies, 1991; Wood, 1982).

Assessment orders.

Almost two decades ago, the Law Reform Commission of Canada (LRCC) reported that, in pre-trial examinations, the relevant issues are fitness to stand trial and the possibility of diversion from the criminal process. The LRCC (1976) recommended that, if fitness to stand trial was the issue for an accused, this should be the only question considered in the psychiatric report, and further, that any information potentially prejudicial to the accused (e.g., the likelihood of committing a similar offence) should be avoided. Grisso (1988:1) supported the LRCC's position by stating that, "If we wish to assist legal decision-makers, then our evaluations must be guided by legal concerns, not simply clinical concerns." This requires that the mental health professionals refrain from reciting to the court their traditional roles (i.e., assess and diagnose conditions that may respond to treatment and benefit their patients), (Veatch, 1986; Whitehead, 1982) because "it is not the diagnosis that is relevant to lawyers but what is going on in the person's mind" (Wood, 1982:5).

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44 Considering changes in the Code, changes in treatment options at F.P.I. and in British Columbia, and the turnover of psychiatric staff, Coles et al. (1993) found no discernible shifts or trends in the diagnoses of mentally handicapped patients during their 15-year study period.

To achieve this, the LRCC recommended that psychiatric reports have two requirements: First, "the judge must decide what information he needs and clearly communicate this to the mental health expert", and second, "the mental health expert must communicate his professional knowledge to the judge in a complete and understandable report" (LRCC, 1976:34). This means that decision-makers must be clear about what specific information is needed in order to reach conclusions about fitness (Golding & Roesch, 1983), and this must be clearly communicated to the mental health professionals who perform psychological evaluations for the courts (Melton et al., 1987).

This communication appears to be missing, and in some cases, ignored. The use of forms indicating the type of evaluation requested by checking off boxes, has been found to be unreliable. Davis (1994:98) reported that forms should not be taken at face value because:

> ... items on referral forms had been (in the past) checked off in an indiscriminate fashion, [and] 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.

As a result, psychiatrists in this study frequently assessed a variety of issues, rarely just one. Not surprisingly, the absence of precise direction regarding the information required by the courts has resulted in psychiatric assessment of issues that extend beyond the scope of the evaluation required or requested, such as recommendations for treatment, recommendations for appropriate dispositions, perceived dangerousness, or even the likelihood of reoffending (Davis, 1994;

Menzies, 1989; Menzies, 1991).[45] While it has been often stated that mental health professionals are to aid, not usurp, judicial decision-making (LRCC, 1976; Melton et al., 1987; R. v. Abbey, 1982), it has also been suggested that many courts have come to expect such conclusory opinions (Rogers & Mitchell, 1991) and that "Canadian judges seem increasingly willing to solicit and endorse the expert opinion of forensic psychiatrists" (Menzies, 1991:233). Obviously, the parameters of the court-clinic relationship cannot be dictated by a pre-printed, prone-to-be-ignored form which indicates which assessment is required.

In one case in this study, for example, the clinician who evaluated a dual-diagnosed patient for fitness to stand trial and treatment requirements in 1990 stated in his letter to the court that:

> At his Honour's discretion, whilst on a lengthy period of probation [the patient] should be directed to attend for comprehensive professional assistance in regard of the above enumerated complex psychological/behavioural problems that he has been troubled with.

In another instance in 1990, a report on the evaluation of fitness to stand trial of an MC patient included another clinician's statement that, "I do not think that incarceration really has much to offer [this patient]."

While it is acknowledged that the clinicians may be in a position to offer their professional opinions *concerning* how patients would respond to specific dispositions (Bonnie & Slobogin, 1980; Rogers & Mitchell, 1991), it would appear to be more appropriate to suggest that if an individual is convicted, the court should request a

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45 Appelbaum (1985) suggested that in instances where the clinician believes that future violence is likely, s/he should feel compelled to take measures to prevent it, even if it is outside the scope of the evaluation. This suggestion is based on the ruling in Tarasoff v. Regents of the University of California (1976) which requires mental health professionals to take all reasonable steps to protect identifiable victims if they know or should know that the patient would commit a violent act.

pre-sentence report. Suggesting or commenting on dispositions at a pre-trial stage extends far beyond the purpose of evaluations of fitness to stand trial: "Psychologists and psychiatrists who assess legal competency must determine whether a defendant's understanding of legal proceedings and ability to work with an attorney are impaired, and then make an inference as to the legitimacy of any observed impairment" (Johnson et al., 1990:181).[46] Discretionary practices in both the evaluation process and the decision-making process threaten the reliability and validity of final decisions (Roesch, Webster & Eaves, 1984), more so because the final decisions are based on psychiatric evaluations which produce educated guesses, not scientific facts (Wood, 1982).

Psychological testing.

In clinical assessments, the choice of techniques is influenced by the differences between defendants in their capacities and the questions that their cases raise (Grisso, 1988b; Grisso, 1992). In evaluations of fitness to stand trial, clinicians can employ traditional assessment techniques, such as interviews and psychological tests which also serve as diagnostic tools, and specialized psycho-legal measures of fitness to stand trial (Rogers et al., 1990). It has been suggested, however, that "the extent to which these interviews would address in any meaningful fashion the issue of fitness to stand trial is highly dependent on the particular examiner" (Rogers & Mitchell, 1991:97).

Psychological tests provide objective measures of a number of factors, such as IQ, personality variables and the level of an individual's development or capacity to develop (Maloney, 1985; Sternlicht & Martinez, 1985). For example, Katz (1985)

46 This is the standard outlined in Dusky v. United States, 1960.

suggested that the best tests for assessing mental retardation and patients with mental retardation are Wechsler intelligence tests, the Bender-Visual Motor Gestalt Test, and the Draw-A-Person test.[47] In this study, however, these tests were used most often with non-MC and dual-diagnosed patients, and not MC patients.

Intelligence tests were administered to many of the subjects in this study. This finding is consistent with other research that indicates that "the measurement of intelligence is one of the oldest branches of psychometric research" (Kline, 1993:422). The Wechsler scales (Wechsler Adult Intelligence Scales (WAIS) and WAIS-R) and Raven's Matrices have been evaluated as accurate measurements of intelligence, and the choice of Wechsler scales for MC and dual-diagnosed subjects in this study conforms with the suggestion that these are appropriate evaluation tools for individuals with mental retardation (Drummond, 1992; Katz, 1985; Sternlicht & Martinez, 1985). In the 15-year review of F.P.I. admissions, Coles and his colleagues (1993) found that 88% of mentally handicapped patients had formal assessments of intellectual functioning, and the WAIS scales were administered in over half of the cases.[48]

Structured and projective personality tests are used to assess affective aspects of behaviour that are not directly related to an evaluation of intelligence (Sternlicht & Martinez, 1985). Structured personality tests, such as the Minnesota Multiphasic Inventory (MMPI), rely on the subject's previous knowledge and abilities, whereas

[47] See Appendix D for a brief description of psychological tests.

[48] In a study by Spruill and May (1988) on the use of intelligence tests for MC offenders, scores on intelligence tests were affected by anxiety at the time of admission to the prison and a group-testing situation. They concluded, however, that in a clinical situation, individually administered tests are considered a valid estimate of intellectual functioning. It is not known what effect, if any, anxiety of admission to F.P.I. has on performance on intelligence and other tests.

projective tests, such as drawing exercises and the Thematic Apperception Test (TAT) and the Rorschach inkblot test, present the subject with unfamiliar situations and tasks which the psychiatrist interprets (Maxmen, 1986). The way the subject approaches the test is also considered.

In the structured test category, the MMPI, which is a self-report questionnaire, was the most frequently employed measure of personality traits for subjects. For individuals with mental retardation, it was noted that there is a risk that the subject might not be able to understand what is being asked because of inadequate reading ability, inadequate comprehension, or limited intellectual ability (Greene, 1991).[49] Drummond (1992) indicated that the MMPI was most suited to assessing psychotic, neurotic, sociopathic and schizoid diagnostic categories.

The Rorschach and TAT, perhaps the most famous projective tests, were used less frequently for subjects in this study, and as Kline (1993:486) explained, these tests "deserve experimental use, if objectively scored, in those cases where personality questionnaires would seem unable to capture the richness and subtlety of the psychological material." The Draw-A-Person test and House-Tree-Person test are appropriate personality assessment tools for individuals with mental retardation, as well as individuals with neuroses (Drummond, 1992). This is not to suggest, however, that any attempt at testing will be successful. For example, in one situation, testing was discontinued because both the tester and the patient were getting too frustrated. In another instance, the clinician explained the difficulty in testing a male patient diagnosed with moderate mental retardation:

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49 Greene (1991) reported that the MMPI-2 can be presented orally by an audiotaped version and it is then effective for individuals with reading and education levels as low as the third grade and IQs as low as 65.

> He followed simple directions, and appeared to understand simple words such as "house", "tree", "man", "draw", but most instructions had to be repeated several times, and were accompanied wherever possible by simple pantomime. His speech appeared to be limited to a singe two-syllable sound which could have been "that one?" and "all done."

A variety of psycholegal instruments are available to assist clinicians in their assessment of the issue of fitness to stand trial (Rogers & Mitchell, 1991; Savage & McKague, 1987). The consistent use of specialized measures developed especially for a specific psycholegal issue, such as fitness to stand trial, should increase the standardization of the evaluation process and decrease sources of bias (Grisso, 1986; Rogers et al., 1990). But it has been argued that, "interest in psycholegal measures has remained largely academic as a majority of forensic centres and individual practitioners continue to employ traditional interview and psychometric methods" (Rogers et al., 1990:536).

This under-usage is not due to a lack of variety of standardized competency tests. First, there is the Competency Screening Test (CST), which involves a sentence-completion task and the Competency Assessment Instrument (Lipsitt, Lelos & McGarry, 1971; McGarry, 1973). The test asks, for example, "When I prepare to go to court with my lawyer ..." (Question #5), and "When they say a man is innocent until proven guilty ..." (Question #18). Research indicates, however, that open-ended questioning formats, and the CST in particular, may not produce accurate results with defendants with mental retardation (Chellson, 1986; Everington, 1990; Rogers & Mitchell, 1991). A study of adults with mild mental retardation, found that:

> The adults were found to exhibit problems related to the semantics of the sentence (e.g., the selection of incorrect vocabulary), the cohesion between sentences (e.g., misuse of articles and pronouns), and segments of the narrative (e.g., absent or ill-formed summary statements, incorrect temporal sequence of events related to the story (Bedrosian, 1985:275).

One case in this study illustrates this point. The clinician wrote of a male patient with unspecified mental retardation:

> [The patient] was unable to give a narrative of the incident leading to his arrest. [He was] dimly aware that he did something "wrong" but was unable to explain why what he did was wrong. At first he stated that he had "kissed the boy" and denied any further contact. When confronted with the statement that "The boy said you touched him between his legs" the patient replied, "I guess I did then."

Chellson (1986) found that if Competency Screening Test scores alone are used to determine fitness to stand trial, competent subjects may be judged as incompetent. In this study, only one standardized fitness test, the Competency Screening Test, was administered, and of the three subjects who received the test, one was diagnosed with mental retardation.

Other fitness assessment tests include the Interdisciplinary Fitness Interview, which assesses the individual's comprehension of legal issues (Golding, Roesch & Schreiber, 1984). In 1984, the Competency Assessment Instrument was revised in the form of the Fitness Interview Test, which its authors described as "a well-developed interview guide rather than a fully established psychometric instrument with known properties" (Roesch, Webster & Eaves, 1984:x).

The obvious lack of an assessment instrument appropriate for use with defendants with mental retardation has only recently been remedied. The Competence Assessment for Standing Trial for Defendants with Mental Retardation (CAST-MR) is the first validated fitness instrument for adults with mental retardation (Everington, 1990; Everington & Luckasson, 1992b). The CAST-MR uses open-ended questioning, and vocabulary and syntax appropriate for individuals with lower levels of linguistic ability, and its focus is on legal criteria for fitness, rather than a diagnosis of mental illness (Everington, 1990). The CAST-MR involves questions in the areas of basic

legal concepts, skills to assist the defence, and understanding case events. For example, in the assessment of comprehension of basic legal concepts, Question #1 asks, "A witness is someone who ... a. sits on a jury; b. works in the court; c. saw the crime." Evaluation of skills to assist the defence includes questions such as Question #31: "What if your lawyer asks you to do something you don't want to do like getting a haircut? What would you do? a. tell him why you don't want to; b. ignore him and do what you want to; c. fire the lawyer on the spot." Finally, assessment of the individual's understanding case events does not involve multiple-choice questions, but rather questions such as "Tell me what happened when the police came" (Question #46), (Everington & Luckasson, 1992a). The results of three separate studies indicate that the CAST-MR provides reliable scores and discriminates between groups of criminal defendants with mental retardation (Everington, 1990; Everington & Dunn, 1992; Everington & Luckasson, 1992b). Discussion of the merit of this instrument is academic, however, if evaluators are not encouraged to use it with defendants with mental retardation who are referred for fitness evaluations.

DSM diagnoses.

While the DSM system does not require a specific interviewing technique, it does increase the standardization of interviews (Shea, 1990). The multi-axial system also allows patients to receive more than one diagnosis. In this study, for example, only six of 30 non-MC and three of eight MC subjects had a single diagnosis.

Research indicates that individuals with mental retardation are vulnerable to mental disorders (Benezech, Bourgeois & Yesavage, 1980; Eaton & Menolascino, 1982; Maxmen, 1986; Menolascino, Wilson, Golden & Ruedrich, 1986; Sovner & Hurley, 1983). In the current study, psychoactive substance use disorders and

personality disorders were the most frequently diagnosed conditions among dual-diagnosed subjects.

The increase in the number of dual-diagnosed subjects from the baseline year to the two other study years is noteworthy. The issue of co-existing mental disorder and mental retardation is becoming a significant concern in the mental health community. In a lecture on this topic, Heaton-Ward (1977:532) spoke of the controversy surrounding "the attitude of those of our medical and nursing colleagues in the mental handicap field who take the view that patients who develop a superimposed mental illness should be transferred for treatment to a mental illness hospital."

One of the greatest problems affecting psychiatric referral of individuals with mental retardation is the difficulty of diagnosing a formal psychiatric illness in MC individuals, especially if the mental retardation is severe (Ghaziuddin, 1988). For example, one study found that masked depression in individuals with severe mental retardation is the most obvious disorder to be overlooked (Fraser, Leudar, Gray & Campbell, 1986). Other problems concerning dual diagnoses arose from psychiatrists and psychologists who asserted that behavioural and emotional disorders in their MC clients were attributable to mental retardation alone (Senatore, Matson & Kazdin, 1985). Finally, communication deficits may result in the failure to detect clinical features during the psychiatric interview (Fraser et al., 1986), although one psychiatrist expressed that as his clinical experience increased, he became more aware of symptoms that would warrant an investigation of mental retardation.

The trend towards acknowledging dual diagnoses can be attributed to several factors. Gilligan (1990:353), for example, stated that when service delivery for MC individuals shifted from institutions to the community, there was an increased

recognition that psychiatric illness in individuals with mental retardation was a serious issue. Second, while deinstitutionalization may have decreased instances of the "institutional syndrome of detachment" (Eaton & Menolascino, 1982), stresses of community living may have increased or exacerbated psychiatric problems (Gilligan, 1990; Reiss, 1982), and it has been suggested that MC individuals' "cognitive deficits and concrete coping mechanisms modify their response to environmental stress and at times make them react inappropriately to everyday provocation" (Ghaziuddin, 1988:495). Finally, successful community placement may be jeopardized if psychiatric disorders are not identified in MC individuals, since the failure to address the mental illness prevents maximization of the person's intellectual and social capabilities (Ruedrich & Menolascino, 1984).

In their study conducted at F.P.I., however, Coles and his colleagues (1993) found a significant number of undiagnosed cases of borderline mental retardation, and suggested that there is a "general bias in our psychiatrists towards under-diagnosing 'borderline mental retardation' among forensic patients" (p. 31). There were instances in this study, however, that point towards an increased understanding of the co-existence of mental disorders in MC patients. In three cases, two different clinicians explained how mental retardation or symptoms of mental retardation fit with diagnoses of mental disorder:

> *Individuals with low intellect, or organic brain damage, are unusually prone to development of paranoia due to their tendency to misperceive environmental clues.
>
> *Results of the present assessment would be consistent with a diagnosis of a psychopathic/antisocial personality disorder.. They can also be seen to be indicative of limited impulse control that is secondary to both a feeling of social frustration and borderline intellectual and educational resources that in large measure contribute to the frustration and also place limits on his ability to respond to it.

> *[The patient received] a diagnosis of marked feelings of inadequacy and inferiority secondary to a specific impairment of cognitive ability and associated social reactions.

These few cases indicate that at least two clinicians have an understanding of the relationship between mental retardation and mental disorder, and the importance of diagnosing both conditions. As well, one other study found "strong associations between mental health diagnoses, behavior problems, and cognitive ability not related to social skills" that "with considerable accuracy" assist in the prediction as to which individuals will be given a dual diagnosis (Borthwick-Duffy & Eyman, 1990:593). There is still support, however, for the conclusion that any defendant with recognizable deficiencies in intellectual capacity should be evaluated by forensic clinicians who have special skills with mental retardation (Raetzen, 1977; Bonnie, 1990). Regardless, it is hoped that this increased number of dual-diagnoses indicates that diagnosing psychiatrists have recognized the importance of addressing mental disorders in mental retardation.

Clinical impressions.

The finding that MC subjects were regularly viewed as cooperative, vulnerable, and approval-seeking is consistent with other studies which documented the suggestibility and vulnerability of individuals with mental retardation (Chellson, 1986; Conley et al., 1992; Montgomery, 1982; Perske, 1991; Sauget et al., 1988). For example, in this study, an outstanding feature of one patient who was diagnosed with moderate mental retardation and "functioning below 10 years of age" was his "willingness to please others."

> [The patient] is almost always polite and compliant to staff direction. He is usually smiling and laughing to situational occurrences. He has at no time displayed violent behaviours or sexual desires towards other patients.

And of another patient with moderate mental retardation who was also "functioning mentally below 10 years of age," the clinician wrote that:

> Due to his low mental functioning and his willingness to please others, one must consider the potential for being preyed upon by others.

The issue of suggestibility has serious implications for individuals with mental retardation in the criminal justice system. Ellis and Luckasson (1985) reported that MC individuals will seek the approval of authority figures even if it requires giving an incorrect answer. For example, Grubin (1991:543) reviewed 259 cases of defendants found unfit to plead in England and Wales between 1976 and 1988, and reported that seven MC defendants had confessed despite other evidence that did not clearly link them to the crimes. In a celebrated case in the United States, detectives were successful in obtaining a confession from a 37-year-old man, David Vasquez, even though he stated several times that he did not know anything about the crime. After reminding the accused that he cut venetian blind cords for the crime, the detectives continued their questioning:

> Detective: "Okay, now tell us how it went, David--tell us how you did it."
> Vasquez: "She told me to grab the knife, and, and, stab her, that's all."
> Detective: (raising his voice): "David, no, David."
> Vasquez: "If it did happen, and I did it, and my fingerprints were on it..."
> Detective: (slamming his hand on the table and yelling): *You hung her!"*
> Vasquez: "What?"
> Detective: (shouting): *"You hung her!"*
> Vasquez: "Okay, so I hung her" (as cited in Perske, 1991:16).

The real murderer was eventually caught and Vasquez was pardoned five years after this interview was recorded. This segment of the interrogation of Vasquez, which was published in a Washington newspaper, sounds familiar. Recall that a clinician wrote earlier that when an MC patient was "confronted" with the statement that he touched the complainant between the legs, he responded, " I guess I did then." This suggests

that special interviewing techniques must be used with MC accused persons, and some clinicians are not employing these techniques, which raises questions about the validity of their assessments.

Sauget and her colleagues (1988) stated that individuals who are highly suggestible can give several different versions of the alleged offence in different interviews. Indeed, in their discussion of a defendant with mental retardation who was recommended as being competent to stand trial, Thompson and Boersma (1988:2) wrote:

> When first questioned by officers, Jim reportedly stated that his father had fallen against a TV set and then against the glass in a screen door, breaking it with his head. As the physical evidence did not appear consistent with this report and because the sequence of events described was confusing, officers again asked Jim to tell them what had happened. Jim's story reportedly changed and was again different when questioned a third time. The officers, believing Jim was confused as to what had happened, asked him to recount step by step what had occurred. Jim's story at this time was reportedly different from any of the previous stories he had given.

In another instance, an man with an IQ of 49 who confessed a murder to police also confessed to the assassinations of President Lincoln, President Kennedy, and President Reagan (Smith, cited in Perske, 1991).

The vulnerability of individuals with mental retardation identified by clinicians presents another set of unique problems. For example, one patient who was incarcerated for a sexual offence was a "passive recipient" of homosexual acts during his detention. Considered to be "easy targets", MC individuals are often victims of extortion, harassment, sexual assaults, and manipulation by others, especially for illicit activities such as drug dealing and rule infractions, in the correctional system (Denkowski & Denkowski, 1985; Garcia & Steele, 1988; Reed, 1989). Also, the judgment in the Texas case of Ruiz v. Estelle, (1980) acknowledged that mentally

handicapped individuals in prisons are often physically, emotionally and sexually exploited and victimized.

The vulnerability, suggestibility, and eagerness to please others generally characteristic of MC individuals have implications for their placement in institutionalized settings such as F.P.I. and prisons (Endicott, 1991; Perske, 1991). The problems caused by MC individuals at F.P.I. were more likely to involve inconveniences to nursing staff, such as staff having to frequently redirect patients and deal with overly friendly behaviour. Problems associated with MC individuals in correctional facilities are likely to be more severe, and this concern was voiced, albeit prematurely, by clinicians in this study.

Letter to court and dicharge status.

As reported in R. v. Steele, (1991), to be capable of conducting his or her defence, an accused must be able to distinguish between pleas, understand the nature and purpose of the proceedings, including the roles of the judge, jury, and counsel, and communicate with counsel rationally or make critical decisions based on counsel's advice, or take the stand to testify, if necessary. A defendant is "technically fit" if he or she is "cognizantly aware of the charges against him, the officers of the court, the possible pleas available to him, all the technicalities of the court" (R. v. Taylor, 1992:557).

The findings of this study are consistent with the requirements as stated above. For example, patients recommended as being fit to stand trial stated that an oath meant to swear to tell the truth, that the defence counsel "defends your innocence" or "usually tries to get the best deal he can for his client", and that the judge "hears the case and passes sentence of guilt or innocence" and "weighs all the evidence and makes the final

decision, either guilty or not." In contrast, a patient recommended as being unfit to stand trial stated that oath was "giving it over to Satan", and the judge was "back-stabbing maybe" or "an a**hole and a f***ing cowboy." Other studies confirm that diagnoses of psychosis are more likely to reflect impairment of a defendant's legally relevant functional abilities than diagnoses of personality disorder and substance abuse (Johnson et al., 1990; Nicholson & Kugler, 1991).

An impaired contact with reality obviously resulted in recommendations of unfitness to stand trial, because, as one clinician stated, the accused was "unable to give meaningful instruction to legal counsel." An understanding of the roles of criminal justice personnel is irrelevant in such situations, for as one clinician wrote of one patient who believed that arson was an anti-Christ charge:

> He can parrot the roles of the officers of the court and the general purpose of the court process but he is markedly delusional as to how this process refers to him and his role within it. He believes that this is a plot by the church that involves the court process, the judges, the police and even the hospital.

An MC patient was recommended as being unfit to stand trial because of his "fluctuating orientation to time, place, and situation and fluctuating memory."

A basic understanding of the role of the court and personnel has been considered adequate for a finding of fitness to stand trial, unless there exists psychoses or delusions. For example, a clinician wrote to the court that one dual-diagnosed patient with unspecified mental retardation:

> ... has a rather simplistic and child-like appreciation of the procedures in Court but on the whole I believe he understands the process, the nature of the charges, and the consequences that may flow from pleading either guilty or not guilty.

So even though this patient's understanding was similar to the understanding of "someone from age seven to twelve", the clinician felt that his degree of comprehension

was sufficient for him to endure the rigours of the criminal trial. Unlike other studies which show that mental retardation or limited intelligence will impair a defendant's ability to proceed with his or her trial (Nicholson & Kugler, 1991; Petrella, 1992), only one MC subject in this study was recommended as being unfit to stand trial, while five dual-diagnosed subjects received this recommendation. It may be that a co-existing clinical syndrome is viewed as more detrimental than a single diagnosis of mental retardation. Another possibility is that some clinicians are unaware of how MC defendants would function in a court setting (Perske, 1991). Or it may be that the level of mental retardation was not considered severe enough to impair the ability to meet minimum competency standards. Finally, it may even be that more intellectually impaired individuals are not diagnosed as such, because as Coles and his colleagues (1993:34) found, there is a tendency that "a marginal or 'borderline mentally retarded' diagnosis are [sic] frequently omitted in favour of more clearly psychiatric diagnoses of behaviour and personality disorders." An impaired contact with reality may be more recognizable than an impaired intellect, and it has been found that some prosecutors argue that defendants fake mental retardation. Luckasson (as cited in Perske, 1991:41-42) collected actual statements of prosecutors, defence lawyers and judges who stated why the defendant could not possibly be mentally challenged:

... because he doesn't drool.
... because you can see how normal he looks.
... because he's so mean.
... because he played cards with the police officers who bring him over in the van, and one day he won.
... because he can write/draw.
... because I know he's mentally ill.
... because I can talk to him easily. He's one of my favorite clients. He does everything I want him to.

In R. v. Brigham, (1992:386) Fish, J. A. of the Quebec Court of Appeal stated that an accused is not "constitutionally protected against acting contrary to this [sic] own best interests." In one case in this study, the clinician had to address a similar issue with one non-MC patient who was recommended as being fit to stand trial. The clinician stated that the patient's depression "may have self-defeating attitudes that pose a question of fitness, though not at this time." In light of Brigham, supra, it can only be speculated whether self-defeating attitudes would result in a patient's acting contrary to her or his best interests or if these attitudes would result in an inability to make full answer and defence which is guaranteed under the Charter of Rights and Freedoms.

The communicative aspect of the trial has been identified by clinicians in some of the cases in this study. For instance, one dual-diagnosed subject diagnosed with moderate mental retardation who had "limited communication skills" was recommended as being unfit to stand trial. Other clinicians indicated clearly that special attention would be required of the defence counsel and, at times, the court. For example, some clinicians were of the opinion that certain MC and dual-diagnosed defendants would require extra assistance as well as a patient, sympathetic defence counsel to get through the trial.

A current Nova Scotia case involving a deaf and mute man facing criminal charges has highlighted the problem of impaired communication skills in terms of the defendant's ability to defend himself ("Justice to turn blind eye", 1993; Flaherty, 1994; Thorne, 1993). Although the accused has no mental disability, his inability to communicate has caused a legal dilemma because he cannot communicate his own evidence and the Crown evidence cannot be communicated to him. The resolution of

this case, which has garnered national attention of legal scholars, may have significant repercussions for MC defendants who have communication difficulties.

The special needs of MC and dual-diagnosed defendants have been acknowledged in the cases reviewed in this study. A recommendation of unfitness to stand trial is most likely when the defendant is delusional. The statements by clinicians that certain defendants would require special assistance is certainly commendable, but it is not known whether these recommendations have been realized once the defendant went to court.

Treatment recommendations.

Treatment is another area where clinicians stated their opinions without a clear request from the court, although as Steinbock (1976:28) argues, suggesting "a plan for therapeutically removing the problem" is part of the diagnostic process. Furthermore, it has been stated that "clinicians often see it as their professional obligation to provide treatment recommendations whenever a treatment need exists with even the slightest prospect of positive change" (Rogers & Webster, 1990:577).

Multiple treatment recommendations were frequent in this study, and in some cases, addressed several deficits or problems. Hunter (1979) argued that because the causes of mental impairment and crime are multifactorial, treatment must reflect a multi-faceted approach, through environmental, physical, education, social, and psychological approaches. For example, for one dual-diagnosed subject in this study, the clinician suggested "rehabilitation programs because of intellectual and social deficits, academic training, occupational endeavors, and sex education" as necessary components of the treatment plan.

Medication was suggested for almost one-third of the dual-diagnosed subjects in this study. The treatment of any coexisting medical disorders in dual-diagnosed individuals usually has the effect of reducing the likelihood of future concurrent psychiatric disorders (Ruedrich & Menolascino, 1984). By reducing the effects of a psychosis, for example, an MC individual is given the opportunity to function more effectively in day-to-day activities.

Supervision and/or group home residency was overwhelmingly suggested for subjects in the MC and dual-diagnosed groups. For successful supervision in the community, the type of deficits, treatments administered, and adjustment in the community must be monitored (Heilbrun & Griffin, 1993). In British Columbia, the Inter-Ministerial Project (IMP)[50] was developed to "extend the length of community tenure and to improve the quality of life of the mentally disordered offender by preventing or reducing the number of rehospitalizations or reincarcerations" (Wilson & Buckley, 1992:226). This project involves frequent contacts by case managers with clients, a long-term commitment to clients, a team approach involving shared caseloads, explicit goals of preventing rehospitalization and reincarceration, assertive case management on behalf of clients, anticipation and prevention of life crises, and home visits and intervention (Id.).

While Day (1990) conceded that the majority of MC offenders can be managed in the community under the supervision of probation or mental handicap services, there are instances in which some individuals do require a period of in-patient hospital care. It has been acknowledged in other research and by one clinician in the current study, however, that one "critical problem" in the provision of community

50 The IMP, an assertive outreach program, was developed by the B. C. Forensic Psychiatric Services Commission, the B. C. Corrections Branch, and the Greater Vancouver Mental Health Service (Wilson, Tien & Eaves,1992).

services is the rejection of responsibility for MC offenders by many health and correctional professionals because they view MC offenders as being unsuitable for their treatment programs (Ruedrich & Menolascino, 1984). For example, in a discussion paper on mental health legislation, the British Columbia Ministry of Health Consultation Committee (1992:7) proposed a definition of mental disorder, based on the Uniform Mental Health Act, that expressly excluded mental handicaps but recommended consideration of "the individual's cultural context."[51]

The problem goes even further, according to Chellson (1986), who viewed as a dilemma the conflict between the due process model (i.e., incarcertion) and the protectionist model (i.e., treatment), especially if treatment resources are available in the community which would offer a greater chance of successful rehabilitation. For example, in one study of an in-patient hospital treatment program, offenders who committed crimes "against the person" had a significantly better prognosis in terms of overall assessment and subsequent convictions than offenders who committed crimes against property (Day, 1990). It was suggested that, for MC offenders, poor-self control was a factor in the commission of crimes against the person, such as sexual assault and physical assault, and that self-control was more responsive to treatment, whereas the factors associated with the commission of crimes against property included poor lifestyle and cultural influences which were not seen as responsive to treatment initiatives (Id.).

Pharmacological intervention and educational approaches are often integral parts of the forensic treatment programs in the United States (Clark, Holden,

51 "'Mental disorder' means a substantial disorder of thought, mood, perception, orientation or memory that seriously impairs judgement, behaviour, capability to recognize reality or ability to meet the ordinary demands of life" (B. C. Ministry of Health, 1992:7).

Thompson, Watson & Wightman, 1993). Attention is directed toward mental illness and behavioral difficulties, and treatment usually involves educating the patient about basic legal concepts (such as pleas), courtroom procedures, and effective ways of communicating with counsel (Marques, Haynes & Nelson, 1993). Hodgins (1993:192) reported that, "The mentally disordered found NGRI [not guilty by reason of insanity] or NFST [not fit to stand trial], receive much attention from mental health professionals; most of those sent to the penitentiaries receive no treatment." More often in security hospitals than psychiatric or general hospitals or correctional facilities, treatment addresses mental disorders, aggressive behaviour, life skills deficits, social skills, and work skills (Id.).

While the appropriateness of a psychiatric approach to treatment of MC individuals has been advocated by some (Day, 1990; Endicott, 1991; Veiel et al., 1993), others have shown a marked discrepancy among mental health professionals treatability (Jackson, 1988; Quinsey & Maguire, 1983). These studies suggest that a lack of consensus among mental health professionals prevents the development of specialized treatment programs (Id.). The answer to this quandary may be provided by Menolascino (1984:436) who argued that mental health professionals must support various approaches that "break with the traditional-professional postures of the past." He suggested three directives applicable to treatment of mentally disordered and mentally handicapped individuals:

1. A sociobiological approach to assessment and treatment

2. Willingness to utilize and integrate professionals from other disciplines who can actively contribute to the remediation model

3. A posture of active and responsible advocacy, which implies, by definition, a strong positive belief in the possibility of the chronically mentally ill

> individual's potential for growth--and a willingness to gain public support for this potential (Id.).

This approach would appear amenable to many advocates of mentally challenged individuals who argue that defendants with special needs should be accommodated so they may face justice, and receive treatment, rather than use their disabilities to avoid justice or receive special consideration (Flaherty, 1994; Gelman, 1986; Menninger, 1986).

Implications of the Study

It is undisputed that fitness to stand trial is a multifactorial concept. For this reason, mental health professionals, and psychiatrists in particular, have found themselves serving a dual purpose: attending to their patients, and responding to the courts. This study raises questions about the fairness of forensic processing of defendants with mental retardation who are referred for fitness evaluations, and how the flow of information from the mental health system to the criminal justice system may be detrimental to the accused.

Scope and limitations of the study.

While this study was exploratory in nature, it is still necessary to be cognizant of reservations about the data, findings, and inferences. First of all, the research is accurate only insofar as the diagnoses are accurate. Diagnostic practices are fallible (Kline, 1993; Menzies, 1991; Savage, 1981; Veiel et al., 1993; Wood, 1982), and, as Coles et al. (1993) have shown, borderline mental retardation, especially, often escapes diagnosis. Also, the absence of dual-diagnosed subjects in the first year and the presence of only one MC subject in the final year may suggest either an increased willingness of psychiatrists to diagnose co-existing mental disorders, or to focus on mental disorders primarily, and mental retardation only secondarily.

Second, this study included only those accused individuals who were caught, referred to F.P.I., and diagnosed with mental retardation. This reduces the generalizability of the findings, but raises questions similar to the "dark figure" of crime (Griffiths & Verdun-Jones, 1994), which suggests that MC individuals are under-referred for fitness evaluations (Bonnie, 1990; McGarry, 1973). It is also possible that fitness is not raised in some instances because the counsel were unaware of the possibility of the existence of mental retardation (Sauget, Wightman & Everett, 1988), or the accused successfully hid his or her disability (Edgerton, 1967; Ellis & Luckasson, 1985; Perske, 1991; Rogers & Mitchell, 1991), or the accused confessed and pled guilty to the charges (Perske, 1991; Petrella, 1992).

A host of other variables were also operating during the course of the study. For example, the high turnover rate of psychiatric staff has already been discussed, although Coles et al. (1993) found no discernible shifts in diagnosic practices pertaining to mental retardation. There was also a period in June and July, 1990 during which a nursing job action was in effect, which resulted in the absence of some information in patients' files. Finally, the effect on psychiatrists and lawyers of the on-going discussions concerning mental health legislation reforms (British Columbia Ministry of Health Consultation Committee, 1992) and of new concepts arising out of court decisions (e.g., the "limited cognitive capacity test" in R. v. Taylor, 1992)[52] is unknown.

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52 There was no doubt that the accused understood the nature or object of the proceedings and the possible consequences of the proceedings, but it was argued (by the Crown) that he was unable to communicate with counsel. In the "limited cognitive capacity test" the question is whether the accused "can recount to counsel the necessary facts relating to the offence in such a way that counsel can then properly present a defence" (R. v. Taylor, 1992:553).

The small number of subjects in the MC group (8) and dual-diagnosed group (14) does not diminish the contribution of this study, however. Canadian court cases such as Brigham, Taylor, and Evans, supra, indicate the continuing importance of the doctrine of fitness to stand trial. The relevance of the doctrine to defendants with mental retardation is slowing being recognized in Canada. The celebrated case of Emerson Bonnar who was institutionalized for years even though a guilty plea would have resulted in a two- or three-month detention (Savage, 1980), and the present case of the deaf-and-mute Roy in Nova Scotia (Flaherty, 1994; Thorne, 1993) are indications that there is a place for mental retardation as well as mental disorder in the Canadian criminal justice system. Furthermore, this study responds to the call by Endicott (1991) to conduct and continue research on the plight of mentally challenged defendants in the criminal justice system, so that new approaches and programs can be designed.

Ideally, policy reform would be a positive step in eradicating some of the inequities in the forensic processing of MC accused persons. Such policy reform has been advocated by others: The Law Reform Commission of Canada (1976) urged that court-ordered psychiatric assessments be limited in scope (e.g., evaluate for fitness to stand trial, if that is the issue), and other research also suggested that "extraneous information" flowing from the clinic to the court be curtailed (Jackson, 1986). It has been stated elsewhere that "gratuitous opinions on the subjects of non-psychiatric punishment (as opposed to 'punitherapy') and general deterrence are both valueless and prejudicial" (Schiffer, 1976:340).

Supporting research by Coles et al. (1993) and Veiel et al. (1993) demonstrates problems in diagnosing practices which would be reduced by requiring

the investigation of suspected cases of mental retardation by a diagnosing psychiatrist. This practice would likely reduce the under-diagnosis of borderline intellectual functioning (borderline mental retardation) demonstrated at F.P.I.

Furthermore, while Raetzen (1977) argued that the assessment of mental retardation should be conducted by psychiatrists with training and practical experience in this area, the number of forensic psychiatrists who specialize in mental retardation is unknown (Tanguay & Szymanski, 1980). For this reason, the use of appropriate psycholegal assessment instruments, such as the CAST-MR (Everington & Luckasson, 1992a), which are designed specifically for use with defendants with mental retardation should be encouraged. This would help to standardize fitness evaluations and would be especially helpful in borderline or "questionably fit" cases.

Suggestions for future research.

There is still a dearth of Canadian research on mentally challenged defendants in the justice system and mentally challenged offenders in the corrections system (Endicott, 1991; Menzies & Webster, 1987), and so there is a real need for studies in these areas. First, there is a lack of post-assessment information from the mental health system and criminal justice system (Jackson, 1986; Menzies & Webster, 1987) that would help to identify the extent of judicial endorsement of psychiatric assessments. This would require a case-by-case review of the court's acceptance of, and the judge's comment about the report provided by the psychiatrist. An analysis of transcripts of psychiatric testimony would also assist in the determination of the extent of the court's expectations of the types of information it deems necessary to assist in its decision-making.

Second, it is not known what steps, if any, are being taken to identify inmates with mental handicaps as they enter the correctional system, and this is the starting point for evaluation of existing programs as well as program requirements for not only offenders with mental retardation, but also offenders with other types of impairments, such as brain damage or intellectual impairment. Denkowski and Denkowski (1985) conducted a study that established a national estimate of the prevalence of mental retardation among prison inmates in the United States. A similar study of the Canadian situation would present a national picture of incarcerated MC inmates, as well as indicate how well (or poorly) they are served by programs in the correctional system. This would involve identification and evaluation of existing programs, if any, designed for intellectually impaired inmates in Canadian prisons.

The United States has developed unique programs to deal with MC offenders. For instance, in Nebraska, the Individual Justice Plan, which was developed for developmentally disabled individuals who had a history of non-violent behaviour and contact with the criminal justice system (Morton, Hughes & Evans, 1986), emphasizes community-based alternatives while still holding individuals responsible for their behaviour (Rockowitz, 1986). In Massachusetts, the Specialized Training and Advocacy Program, although short-lived, discovered a need for reliable data on the projected numbers of offenders with mental retardation in the criminal justice system (Moschella, 1986). In British Columbia, the Inter-Ministerial Project represents an assertive approach to reducing the fragmentation of services, but its focus is on "multi-problem offenders [who] typically have a combination of mental illness, severe social or behavioral problems, and substance-abuse problems as well as criminal justice complications" (Wilson & Buckley, 1992:225). There should be an

analysis of the incidence of mental retardation among the caseload and the effectiveness of the project for this specific population of offender, as well as a comparative review with other projects with similar goals.

The importance of small-scale, local research as well as regional studies should not be undermined; however, the development of a national picture has the potential of formulating a unified approach to "bring the quality and quantity of services available ... up to the standards dictated by the law and by the collective conscience of the nation" (Endicott, 1991:43). Until more is known about the existing Canadian situation, we will have to rely on small-scale and regional research in the quest to understand how justice serves mentally challenged persons.

Chapter Seven

Case Studies

The following case studies were constructed from the information recorded in the patients' files. These case studies are presented as a further illustration of the relationship between fitness to stand trial and mental retardation among criminal defendants. The criteria for a patient's candidacy for a case study included clear and complete demographic, social, criminal, and assessment information.

Case Vignette 1

Borderline mentally challenged accused recommended as being fit to stand trial

The first case concerns an accused person who was diagnosed with borderline mental retardation and was recommended as being fit to stand trial. Jake, as this person shall be called, was a 23-year-old single male who lived with friends in a private-home apartment. He was unable or unwilling to live independently. He was unemployed and welfare was his income source. He was currently remanded to F.P.I. on a charge of theft.

Jake was one of five children. All of his siblings were adopted and suffered from various physical and mental handicaps. From ages five to seven years old, Jake was enrolled in a residential treatment program where he received special education and treatment for behaviour problems. He also attended a Skills Development Program until grade 10, and this is recorded as his last year of formal education.

Despite his participation in this program, Jake remained unemployed. Two problems cited as reasons for his jobless status were that he had an irresponsible attitude toward work and he had a lack of motivation.

Jake had one previous conviction for a sexual assault on a seven-year-old girl. His criminal history also included convictions for property offences and thefts from restaurants. For these criminal offences, he received custodial sentences, probation orders, and community work orders. Jake required considerable encouragement and supervision to comply with court orders. If his supervisor did not stay with him while performing his community work service, Jake would leave his assigned task at whim. He ignored probation orders, and on the occasions when he did show up for meetings with his probation officer, he was often late.

While incarcerated, Jake was a passive recipient of homosexual contacts. He asserted that he is not homosexual and did not enjoy these experiences. He never had a heterosexual relationship although he stated that he liked women. His poor sexual knowledge and experience were cited as causes of his sexually inappropriate behaviour.

The current remand was Jake's first admission to F.P.I. The nursing records indicated that Jake was friendly and overly cooperative, but he had to be told on several occasions to "stop hanging around the office."

A number of assessments indicated that Jake's intellectual functioning was in the range of borderline mental retardation, but his behaviour and learning abilities were below this level of functioning. Although it was stated that Jake had a poor memory, he clearly recalled the theft from the restaurant which resulted in his current remand to F.P.I. He stated that he took the money because he wanted to and he knew that this behaviour was wrong. Because he was aware of the nature of his actions, the possible consequences for his behaviour, and was considered able to communicate with counsel, he was recommended as being fit to stand trial.

The clinician, however, clarified the problem of people with borderline mental retardation who commit criminal offences:

> In many ways the system fails people like [Jake]. He is too bright for the Mental Handicap Services, not mentally ill enough for the general Psychiatric services, not sufficiently mentally disordered to be unfit to stand trial or deemed Not Criminally Responsible on account of Mental Disorder, and yet evidently inappropriately placed within the prison system and needing more community care and support than is currently available.

There were no suggestions for on-going treatment. The clinician indicated that the likelihood of re-offending was high.

Case Vignette 2

Mentally challenged accused recommended as being fit to stand trial

Bert, as this person shall be called, was a 27-year-old single male who was employed part-time and was living alone. He was remanded to F.P.I. on three counts of sexual assault and three counts of sexual interference. He was diagnosed with pedophilia and unspecified mental retardation.

Bert was the second of four children, all of whom were mentally challenged. Bert spent five years in a foster home, and during this time, he was frequently sexually molested by his foster parents' son. He stated that he thought that these experiences were the cause of his current sexually inappropriate behaviour. He had limited sexual knowledge, but fantasized about "women with pretty faces" but not about children. Regarding dating, he stated, "I'm not smart enough to get someone for dating. I haven't learned yet." Bert had a previous conviction for the sexual assault of two girls and a previous charge of buggery.

The current charge arose when Bert had three girls playing Nintendo in his apartment. He put suntan lotion on himself and the girls indicated that they wanted some too. He obliged because "they were brown" and he wanted to protect them from

the sun. The lotion was runny and he slipped his finger under the elastic of the girls' waistbands to stop the lotion from running down their legs. Bert did not see his actions as inappropriate, and could not understand why he was charged for applying suntan lotion. He believed that he was behaving responsibly. When the stigma attached to sex offenders was explained to him, he was still unable to understand why people did not leave him alone and mind their own business.

Bert was described as poorly socialized which accounted for his choosing children as companions. While not his preferred company, children are accepting, non-threatening, and do not ridicule or reject him. Bert described himself in fatherly and brotherly terms and liked to take charge in situations in which he felt parents neglected their children. He was often used as a free baby-sitter.

The current remand was Bert's first admission to F.P.I. He was assessed as having a mental age of between seven years and eleven months, and nine years and two months. His memory was poor and he exhibited heavy use of defences such as denial and repression to block out his traumatic sexual experiences. His use of language was odd as he tried to sound more intellectually capable than he was.

Bert understood that he was facing six sex-related charges. He had a simplistic, child-like appreciation of the procedures in court. His understanding of Crown Counsel was weak until he was told that the Crown Counsel is like a prosecutor. Bert then stated that "this guy wants to put me in jail, he is there to tell the police's story." He knew that his potential pleas were guilty and not guilty. He had a "good working knowledge of the arrest procedure and what happens in Court" even though he was insistent that regardless of what he did, he was going to be found guilty, and was perplexed about why he was arrested for simply applying suntan lotion.

Bert was recommended as being fit to stand trial although "much of his appreciation of the charges, the pleas and the process that will ensure from this is somewhat child-like and naive. It must be remembered that any understanding he does manifest will be that of a latency age child (i.e., some from age seven to twelve)." Another recommendation was that, if bound for trial, Bert should be placed in protective custody or returned to F.P.I. to maintain fitness and protect him from sexual assault in prison. This concern arose from Bert's slight stature, perceived inability to protect himself, suggestibility, and naiveté.

The clinician suggested that, if found guilty, Bert should attend the Sex Offender Treatment Program even though his learning would be difficult due to his diminished mental capacity, inability to remember, and lack of access to memories of sexual experiences. Also, it was stated that Bert needed formal sex education as well as a structured setting for the safety of both Bert and the public.

Case Vignette 3

Mentally challenged person recommended as being unfit to stand trial

This woman, who shall be called Lucy, was 29 years old and living with her common-law spouse in a private-home apartment. She had a variety of mental disorders and disabilities including polysubstance abuse, organic mental disorder, chronic dysthymia, personality disorder, and mild to moderate mental retardation. Lucy was remanded to F.P.I. on charges of setting fires and causing damage to property.

Lucy was one of twelve children and was born with Fetal Alcohol Syndrome. She was six years old when she had her first experience of gasoline intoxication. She attended school infrequently in the first two years of school and then gave up on her education. She would often run away from home and hide. When she was sixteen years

old, she was sent for vocational evaluation and planning. At this time, she exhibited behavioural problems including running way, hostility to personnel in charge, poor peer relations, stealing, lying, immaturity, and hyperactivity. Her voluminous file from Woodlands Hospital detailed her behavioural and intellectual problems and difficulties.

Lucy's past delinquency included charges of arson (she committed her second offense of arson while on bail for the first offence of arson), and shoplifting liquor. With reference to Lucy's failure to attend court-ordered counselling, the clinician noted that "due to [Lucy's] cognitive limitations she has likely not been able to abide by the recommendations and had no sufficient intellectual capacity to benefit from the programs that she was supposed to participate in."

Lucy did not think she should have been arrested for such "a very little fire" in which no one was injured. Also, she believed that her family would prevent the judge from making a disposition that would affect her.

Her file included documentation of child-like and attention-seeking behaviour and attempts to please the nursing staff. The nursing notes indicated that Lucy was considered a "tattletale" as she frequently told staff of what other patients had done. She often approached the staff with multiple petty requests.

Lucy's thinking was described as concrete and questions had to be "over simplified" for her to understand what was being asked. Her limited ability for abstract thinking is illustrated by her responses to the following proverbs: Out of the frying pan -- "like you're cooking something, pancakes when you flip them over", and People in glass houses -- "windows." When asked to name six large cities, she cited

Prince Rupert, Vancouver, Nova Scotia, Hawaii, Toronto, and Terrace. She stated that "Queen Charlottes" was the capital of England.

Lucy tended to give "inappropriate and beyond the point responses as part and parcel of her intellectual retardation." The following excerpts from her interviews illustrate this point:

> Q. What is your date of birth?
> A. I don't know. My mother told me if anyone tried to do something funny to tell her about it. This guy Henry called me mentally retarded. I turned around and got mad.
>
> ...
>
> Q. What does Crown Counsel do?
> A. They don't do much. I don't think ... they are trying to get me out of it. Out of trouble.
>
> ...
>
> Q. What does a judge do in court?
> A. He didn't say much. He just mumbles. Can't even hear him. Can't even hear what he says.
>
> ...
>
> Q. What is a plea?
> A. If I don't I will be shipped away.
>
> ...
>
> Q. What year [is this]?
> A. 20, the 20th.
>
> ...
>
> Q. What day of the week is today?
> A. I don't know. That is the only one I don't know. I've been sent away for so long ... getting sent away too long. Getting my mother so upset. She does not know what to do with me. Told me is getting at me. Now she wants to drink. Gets upset too much because of the arthritis. ... I was doing so good until everything went wrong. Now my brother is going to get Henry for this. I told him I don't want to get the shoes ...

At the end of Lucy's interview, she indicated that she wanted to be called by her middle name because when she was called by her first name, it "paranoids me."

Although Lucy stated that she used matches to set fire to the curtains of a door of one of the units in an apartment complex, the clinician reported that due to Lucy's intellectual and psychological difficulties she:

> ... can't comprehend to an adequate degree the nature and object of charges and legal consequences. Although she has some very rudimentary and basic knowledge related to the court process and advice that she has been given by her counsel, on balance she is by virtue of her intellectual retardation and insufficient knowledge of the judicious [sic] process unable to give proper instructions to her lawyer nor does she have the capacity to enter a meaningful plea. ... Her ability to actively participate in her trial process will be severely compromised by her limited intellectual level. It will be difficult, if not impossible, for her to give counsel anything other than the most obvious explanation of her motivation as it relates to mens rea; and she will require, on site, explanation if she is to follow courtroom procedures.

The clinician wrote that Lucy needed long-term residential care because of her low intelligence, inability to care for herself in the community, and her history of setting fires when she became angry. Lucy's situation can be summed by the clinician's statement that, "Working with her is going to be a difficult process."

Discussion of Case Vignettes

These case vignettes illustrate the nature of the problems encountered by patients who are diagnosed with mental retardation and who commit criminal acts and the problems encountered by clinicians who conduct court-ordered assessments. One common feature is the patients' simplistic reasoning. For example, the sexual connotation attached to the application of suntan lotion was incomprehensible to Bert. Second, the patients' level of intellectual and behavioural functioning was explained. In the case of Jake, it was noted that his behavioural functioning and learning abilities were at a lower level than his intellectual functioning which was in the range of borderline mental retardation. Regarding 27-year-old Bert, the clinician indicated that Bert's understanding of the judicial process would be more like that of a seven- to

12-year-old person. In Lucy's case, the clinician stated that her inappropriate responses were characteristic of Lucy's "intellectual retardation".

A significant problem arises when the recommendations for treatment were considered. Jake had a history of failure to comply with court probation and community work orders, and it was noted that the lack of appropriate long-term treatment for people with borderline mental retardation who are convicted of criminal offences would likely result in Jake's re-offending. Bert's impaired learning abilities and diminished mental capacity were cited as problems which would limit the effectiveness of a sex offender treatment program. Lucy, who was both illiterate and had behavioural problems, presented another dilemma. Her cognitive limitations which precluded previous successful counselling programs, her tendency to set fires when she became angry, and her obvious need for residential care shifts responsibility for Lucy from the judicial system to the mental health care system, although it was apparent that both had failed her in the past.

Summary

Convicted criminals with borderline mental retardation are neither bad enough or mad enough to benefit from the safeguard of unfitness to stand trial, mental handicap services, or psychiatric services. For others, a rudimentary understanding of the criminal justice process may preclude a finding of unfitness to stand trial, but cognitive deficiencies may bar successful attempts to achieve "rehabilitation." And there are others who are clearly unfit to stand trial because of intellectual deficiencies, not because of a mental illness, and attempts to "cure" the mental state will not succeed. These are the problems that define the relationship between fitness to stand trial and defendants with mental retardation.

Chapter Eight

Conclusions

The Forensic Psychiatric Institute services accused persons remanded from the courts. During their remand period at F.P.I., subjects in this study underwent a series of psychological tests and interviews as part of their evaluations. The majority of non-MC and MC subjects were discharged as fit to stand trial, while only half of the dual-diagnosed subjects had a discharge status of fit to stand trial. Admissions of other patients were changed to involuntary admissions. The diagnosing psychiatrist also writes a report to the court to guide judicial decision-making on matters of fitness as well as mental state at the time of the alleged defence, treatment recommendations, and sometimes other concerns not requested by the court, such as disposition alternatives.

The aims of this study were to identify the relationship of fitness to stand trial and defendants with mental retardation, and to evaluate the forensic processing of MC defendants in response to changes in the Code, following the decision R. v. Swain (1991) which prompted a revision of several sections of the Code (Spetz, 1992).

The data revealed that subjects in the MC group were much younger at the time of their admission to F.P.I. than their non-MC and dual-diagnosed co-subjects. This characteristic is the only sociodemographic variable which yielded a statistically significant difference among the three groups. The age difference was consistent in the three study years.

Previous psychiatric history did not appear to be a factor in fitness recommendations, although there appears to be a trend toward an increasing number of readmissions. All of the MC subjects and 13 of the 14 dual-diagnosed subjects had

previous admissions to mental health institutions, and it was not uncommon for their admissions to be lengthy. For instance, one subject spent almost 25 years at Woodlands (Hospital) School, while another spent three years at an institution. In contrast, non-MC subjects were more likely to have much shorter periods of institutionalization, i.e., under 30 days. The reasons for the increasing number of individuals with mental disorders and mental disabilities who are involved with both the mental health system and the criminal justice system is due to a variety of factors, such as deinstitutionalization, criminalization of mental disorders, and medicalization of criminal behaviour.

The majority of subjects in all three groups had previous criminal histories as well, although conviction rates were not statistically significant between the groups. The criminal conviction history and current charges indicated that the most serious offence (i.e., murder) was in the domain of non-MC subjects, as were driving offences. Convictions for, and current charges of, sexually inappropriate behaviour and assaults were frequent among MC and dual-diagnosed subjects. Most of these charges arose from non-violent acts.

Interestingly, some of the charges resulted in disbelief on the part of both the subjects and professionals. For instance, two of the subjects profiled in the previous chapter could not understand why their behaviour attracted so much attention. One lawyer expressed disbelief that a person who slipped his finger under the waistband of a girl's swimsuit would be charged with sexual assault and sexual interference. It was also stated that it was surprising that an elderly dual-diagnosed subject with a history of robberies was continuing to commit robberies and getting away, although he did end up getting caught.

Like the explanation of increased association with the mental health and criminal justice systems, there are several variables that have been put forth as explanations for the criminal behaviour of individuals with developmental disorders. For instance, low intelligence, poor socialization skills, and environmental and economic factors have been suggested as having an impact on the decision to commit criminal acts. Indeed, a common feature of the subjects in this study was unemployment and social assistance income.

There is also a conflict in terms of the roles of the criminal justice system, which some would say is in a crisis period, and the roles of other agencies which prefer to have mentally disordered and mentally challenged defendants diverted from the criminal justice system in an attempt to end the cycle of recidivism and rehospitalization. In conjunction with this conflict is the dilemma faced by police and prosecutors, who are urged by the public to get criminals off the streets, and mental health professionals and community-based services, who are urged by others to rehabilitate offenders via programs not available in correctional institutions. For example, in one case, the psychiatrist suggested that the subject attend a sexual offender treatment program even though it was unlikely that he would learn anything. It appears that this is an attempt to bow to public pressure to deal with the sexual offender and make it appear that justice is being served upon him, although, in fact, the clinician questioned the potential success of the treatment.

An interesting discovery in the area of testing that the subjects underwent is the lack of use of psycholegal assessment measures of fitness to stand trial, although the utility of such measures would help to standardize court-ordered evaluations. Despite the numerous psycholegal measures available, only the Competency Screening

Test (CST) was employed three times, including once for an MC subject although it has been found that the CST is not an appropriate instrument for people with mental retardation. Clinicians opted, instead, for traditional interview techniques and psychometric methods.

There are two obvious reasons why the use of a psycholegal measure designed to assess fitness to stand trial of mentally challenged defendants should be encouraged. First, as in the case of the CAST-MR, the test is written with vocabulary and syntax appropriate for individuals with lower levels of linguistic ability and is designed to assess fitness to stand trial, rather than assess mental disorder. Second, the reliability and validity of assessments has been questioned if clinicians are not trained or experienced in the area of mental retardation. This question appears to be a valid one, since it has been found that there exists under-diagnosing of borderline intellectual functioning. The use of standardized instruments would also assist in controlling the type and amount of information that flows from the clinic to the court.

During the three years, clinicians continued to focus on the three criteria for fitness--first those explained in Roberts, supra, and then the criteria listed in the Code. Of course, medical concerns affected the recommendations concerning fitness, especially in situations where the accused was psychotic or delusional. In other instances, mental retardation did not appear to have a significant impact on recommendations for fitness. For example, one patient with a comprehension level of a seven- to 12-year-old was recommended as fit to stand trial despite his child-like appreciation of the procedures of the court.

There was no discernible trend in assessment practices during the study years. There was, however, a noted change in the length of stay for assessment for all groups.

For the non-MC group, for example, the average number of days changed from 30.7 in the Baseline Year to 21.1 in the Final Year. For the MC group, the average number of days only dropped by three--from 25.3 to 22 (although this may be misleading since there was only one subject in the MC group in the Final Year). Dual-diagnosed subjects, of whom there were none in the Baseline Year, dropped from an average of 33.8 days in the Anticipatory Year to 27.3 days in the Final Year.

The other noteworthy change over the years was the change in diagnoses of MC and dual-diagnosed subjects. The absence of dual-diagnosed subjects in the Baseline Year and the solitary MC patient in the Final Year may represent an increased focus on mental disorder, in keeping with the explanation of unfitness to stand trial in the Code. Given that three dual-diagnosed subjects were recommended as unfit to stand trial in the Anticipatory Year and only two in the Final Year, it is difficult to attribute this shift to legal changes with any degree of certainty. Another explanation is strictly medical in nature; that is, clinicians are now more aware that coexisting mental disorders should be diagnosed in patients with mental retardation. It is important to note, however, the existence of the practice of acknowledging the co-existence, and treatability of co-existing mental disorders in individuals with mental retardation.

Mild mental retardation was the level of mental retardation diagnosed most frequently for both the MC and the dual-diagnosed groups. The dual-diagnosed subjects were diagnosed with mild mental retardation more frequently than other levels of mental retardation; however, unlike the MC subjects, there were no diagnoses of borderline intellectual functioning.

Based on the diagnoses, there is an obvious increase in mental retardation among patients referred to F.P.I. for evaluations. In the Baseline Year, patients with

mental retardation accounted for 1.27% of the cases referred, while in the Final Year, this figure increased to 2.67% of the cases referred. These figures do not indicate an over-representation of patients with mental retardation being referred to F.P.I., since the incidence of mental retardation among the general population is estimated at one to three percent.

Two questions immediately arise from these figures. First, how does the practice of under-diagnosis of borderline intellectual functioning affect the prevalence rates? Second, if other related mental disabilities, such as brain damage or impaired intellect are taken into account, how would the rates be affected? Since the rate of referrals to F.P.I. was fairly consistent during the study period (237 referrals in the Baseline Year to 263 referrals in the Final Year), it is suggested that accurate diagnoses would increase the prevalence rate, resulting in an over-representation of mental handicap among the defendants referred to F.P.I.

The relationship between fitness to stand trial and defendants with mental disabilities is garnering more attention. Recently, a provincial court judge in Nova Scotia stayed sex-related charges against a deaf-and-mute man named Roy (Flaherty, 1994) because he cannot communicate sufficiently with his lawyer or the court to defend himself. At the same time, however, the judge denounced this decision as unsatisfactory. The judge's decision has been described as "an important precedent that a person must be able to communicate to participate in their own defence" (Id.). It is expected that discussion of the legal ramifications of this decision will continue for some time.

This research has shown that MC patients at F.P.I. are different from non-MC patients in terms of age, psychiatric history, and criminal history. The lack of

standardized assessments, however, makes it difficult to determine whether a diagnosis of mental retardation has an appreciable effect on the psychiatrist's ultimate recommendation regarding fitness to stand trial. Increasing numbers of defendants referred for evaluations who are ultimately diagnosed with mental retardation will require treatment programs designed to deal with cognitive deficits, behavioural problems, and poor social skills. The effect, if any, of legal discussions surrounding the case of Roy and the implications for other mentally handicapped defendants remains to be seen.

Appendix A

Coding Manual

1. Identifier code (1-4)

2. Record Number 1 (5)

Part 1: Demographic Information

3. Date of birth (6-11)
   Day, Month, Year

4. Gender (12)
   1=Male
   2=Female

5. Ethnicity (13)
   1=White
   2=Aboriginal
   3=East Indian
   4=Oriental
   5=Black
   9=Unknown
   0=Other

6. Education level at time of remand (14)
   1=None
   2=Elementary (1-8)
   3=Secondary (9-13)
   4=Community college
   5=Technical college
   6=Some university
   7=University degree
   8=Graduate degree
   9=Unknown
   0=Other

7. Income source at time of remand (15)
   1=Self
   2=Spouse
   3=Parents
   4=Other family
   5=Welfare
   6=Government pension
   7=U.I.C.
   9=Unknown
   0=Other

8. Employment status at time of remand (16)
   1=Employed full time
   2=Employed part time
   3=Occasionally/seasonally employed
   4=Unemployed
   5=Retired
   6=Not applicable
   9=Unknown
   0=Other

Part 2: Psychiatric History

1. Identifier code (1-4)

2. Record Number 2 (5)

3. Number of admissions to mental health institutions including FPI (6-7)
   Enter 00 if no previous admissions, 88 if person had extensive history of admissions to mental health institutions, or 99 if unknown.

4. Total time in days for each previous admission (8-12)
   1=1-7 days
   2=8-14 days
   3=15-30 days
   4=31-60 days
   5=Over 60 days but less than one year
   6=Over one year
   9=Unknown

5. Intelligence Quotient (13)
   1=Average to high average
   2=Borderline mental retardation (IQ 71-85)
   3=Mild mental retardation (IQ=50-70)
   4=Moderate mental retardation (IQ=35-49)
   8=Indeterminate
   9=Unknown

Part 3: Criminal History

6. Previous criminal charge (14)
   1=Yes
   0=No
   9=Unknown

7. Number of previous criminal charges (15-16)
   Enter 88 if extensive and 99 if unknown.

8. If previous criminal charge, Criminal Code offence (17-25)
   Allowance for three most recent charges, excluding current charge.

9. Previous criminal convictions (26)
   1=Yes
   2=No
   9=Unknown

10. If previous conviction, Criminal Code offence (27-35)
    Allowance for three most recent convictions.

11. Charge(s) related to present remand (Criminal Code offence) (36-44)
    Allowance for three offences.

Part 4: Psychiatric Assessment Information

1. Identifier code (1-4)

2. Record Number 3 (5)

3. Psychiatric evaluation request for existence of mental illness (including mental handicap) (6)
   1=Yes
   0=No

4. Psychiatric evaluation request for fitness to stand trial (7)
   1=Yes
   0=No

5. Psychiatric evaluation request for mental state at time of alleged offence (8)
   1=Yes
   0=No

6. Psychiatric evaluation request for treatment requirements (9)
   1=Yes
   0=No

7. Psychiatric evaluation request for pre-sentence report with recommendations (10)
   1=Yes
   0=No

8. Admission number (11)
   1=First admission
   2=Readmission

9. Admission date (12-19)
   Day, Month, Year

10. Discharge date (20-27)
    Day, Month, Year

11. Psychometric testing used (28-37)
    Allowance for five tests.
    If no testing or if testing is unknown, enter 99.

12. Clinical impressions (38-41)
    1=Cooperative with staff
    2=Vulnerable or constantly seeks staff approval
    3=Eager to please staff and others
    4=Uncooperative with staff and clincians who perform testing
    5=Unable or unwilling to provide information requested
    6=Unpredictable behavior
    7=Aggressive behavior toward staff and others
    8=Poor or hostile relationship with other patients and staff

13. Contents of letter to court (42-43)
    1=Fitness achieved after treatment
    2=FPI inappropriate for accused
    3=Requires patient, sympathetic defence counsel
    4=Requires extra assistance, e.g., interpreter
    5=Fit but expect behavioral outbursts
    6=Fit but unable to testify
    7=Clearly fit
    8=Unable to be determined
    11=Clearly unfit
    0=Other

14. Axis I diagnosis (44-52)
    Diagnosis based on DSM-III-R (Clinal Syndromes)
    If no Axis I diagnosis, enter OOO.

15. Axis II diagnosis (53-61)
    Diagnosis based on DSM-III-R (Developmental and Personality Disorders)
    If no Axis II diagnosis, enter OOO.

16. Discharge status (62)
    1=Fit to stand trial
    2=Unfit to stand trial
    3=Fitness not determined
    9=Unknown
    O=Other

17. Treatment recommendation (63-66)
    1=Medication
    2=Individual therapy
    3=Group therapy
    4=Supervision/group home
    5=Community outpatient care
    6=FPC outpatient care
    7=Multiple
    9=Unknown
    O=Other
    If multiple, list first three in 64-66.

Appendix B

Offence/Charge Codes

Code	Offence	Criminal Code Offence	
		Old Section	New Section
	1.1 Murder		
111	First degree murder	214	231
112	Second degree murder	214	231
113	Infanticide	216	233
114	Criminal negligence causing death	203	220
	1.2 Manslaughter		
121	Voluntary manslaughter	215	232
122	Involuntary manslaughter	217	234
	1.3 Attempted murder		
131	Attempted murder	222	239
	2.1 Sexual offences		
211	Rape	143 246.1	- - - - - -
212	Attempted rape	245	- - -
213	Sexual assault	- - -	271
214	Sexual assault with weapon	246.2	272
215	Aggravated sexual assault	246.3	273
	2.2 Gross indecency		
221	Acts of gross indecency/exposure	157	173

	2.3 Indecent assault		
231	Indecent assault (female)	149	- - -
232	Bestiality/buggery	155	160
233	Indecent assault (male)	156	- - -
	2.4 Incest		
241	Incest	150	155
242	Stepdaughter/female employee	153	- - -
	2.5 Sexual assault		
251	Statutory rape/aggravated sexual assault	146	173
252	Feeble minded	148	- - -
253	16 to 18 year old	151	- - -
254	Sexual exploitation of 14 to 18 year old	- - -	153
255	Sexual interference	- - -	151
256	Invitation to sexual touching	- - -	152
	3.1 Assault		
311	Bodily harm caused by criminal negligence	204 254.3	221
312	Assault causing bodily harm with intent/wounding	228	244
313	Administer noxious thing causing bodily harm	229.a	245
314	Overcoming resistance to commission of offence	230	246
315	Tampering with transport	232	248
316	Assault causing bodily harm or bodily harm/weapon	245.2 245.1	267

317	Aggravated assault	245.2	268
318	Assault in commission of offence	246.2	272
319	Assault of police officer/ resisting arrest	246.2 246.1	270
	3.2 Kidnapping and abduction		
321	Kidnapping	247.1	279
322	Unlawful/forcible confinement	247.2	279.1
323	Abduction of female	248	- - -
324	Abduction of female under age 16/ abduction of person under age 16	249	280
325	Abduction of child under 14	250	281
326	Hijacking	76.1	76
	3.3 Minor assault		
331	Administer noxious thing	229.b	245
332	Assault	244	265
333	Common assault	245.1	266
334	Intimidation	382	423
	3.4 Driving offence		
341	Criminal negligence in operation of motor vehicle/dangerous driving	233 233	249
342	Failure to stop	233	252
343	Impaired driving/ driving while impaired	234	253
344	Driving over .08	236	253.b
345	Failure to provide breath sample	234	254.5
346	Driving while disqualified	238	259

	4.1 Robbery		
411	Robbery	302	343
412	Attempted robbery	304	660
413	Extortion	305	346
414	Stopping mail with intent	304	345
	5.1 Offensive weapon offence		
511	Possession of weapon or imitation	85	87
512	Concealed weapon	87	89
513	Pointing a firearm	84	86
514	Possession of prohibited weapon	88	90
515	Use of firearm/commission of offence	83	85
	6.1 Property offence		
611	Arson	389	433
	6.2 Minor property offence		
621	Mischief/damage to property	387 388	430
622	Setting fires/damage to property	390	434
623	Fire caused by negligence	392	436
624	False alarm of fire	393	437
625	Cruelty to animals	400 401 402	444 445 446
	7.1 Public order/nuisance		
711	Indecent phone calls	330	372
712	Threatening/intimidation	331 381	423

713	Indecent act/exposure	169	173
714	Public nudity	170	174
715	Disturbing the peace	171	175
716	Obstructing/resisting peace officer	118	129
717	Escaping lawful custody	133	145
718	Trespassing	173	177
719	Failure to appear/breach of probation, parole, mandatory supervision/prison breach/bail	133 666 124	145 749 - - -
720	Vagrancy	175	179
721	Personation	361	403
722	Intoxication	171	175
723	Violation of immigration laws	- - -	- - -
724	Breach of Juvenile Delinquency Act/Young Offenders Act	- - -	- - -
	8.1 Theft		
811	Breaking and entering	306	348
812	Unlawful presence	307	349
813	Possession of housebreaking tools	309	351
814	Possession of stolen property	312	354
815	Theft from the mail	314	356
816	Fraudulently obtaining food/ lodging/transportation	322	363
817	Forgery	324	366
818	Uttering	326	368
819	False pretences	320	362

820	Fraud	338	380
821	Theft	294	334
822	Attempted theft	587	660

9.1 Drug offence

911	Possession, selling, importing, etc.	Narcotic Control Act/ Food and Drug Act

Special categories

000	No offence listed
999	Unknown

Appendix C

DSM-III-R Diagnostic Codes

Code	Diagnosis	DSM-III-R Diagnostic Code
	Special Diagnosis Category	
000	No diagnosis	V71.09
999	Diagnosis deferred	799.90
	1.1 Mental Retardation	
111	Mild mental retardation	317.00
112	Moderate mental retardation	318.00
113	Unspecified mental retardation	319.00
114	Borderline intellectual functioning	V40.00
	1.2 Disruptive Behaviour Disorders	
121	Conduct disorder, group type	312.20
122	Conduct disorder, undiferrentiated type	312.90
123	Attention-deficit hyperactivity disorder	314.01
	1.3 Other Disorders of Infancy, Childhood or Adolescence	
131	Undifferentiated attention-deficit disorder	314.00
132	Specific learning disability	315.20
	1.4 Impulse Control Disorders	
144	Impulse control disorder	312.30
	1.5 Speech and Hearing Deficits	
151	Speech and hearing deficits	784.50

	2.1 Psychoactive Substance Use Disorders	
211	Alcohol dependence	303.90
212	Alcohol abuse	305.00
213	Cannabis abuse	305.20
214	Inhalant/PCP/Psychoactive substance abuse	305.90
215	Opioid abuse	304.00
216	Polysubstance and alcohol dependence	304.90
	3.1 Schizophrenia	
311	Schizophrenia, disorganized type, chronic	295.12
312	Schizophrenia, paranoid type, unspecified	295.30
313	Schizophrenia, paranoid type, chronic	295.32
314	Schizophrenia, residual type, chronic	295.62
315	Schizophrenia, undifferentiated type, chronic	295.92
316	Schizophrenia, undifferentiated type, in remission	295.95
	3.2 Delusional (Paranoid) Disorder	
321	Delusional disorder	297.10
322	Delusional paranoid disorder	297.90
	3.3 Psychotic Disorders Not Classified Elsewhere	
331	Psychotic disorder NOS	298.90
332	Schizoaffective disorder	295.70
	4.1 Bipolar Disorders	
411	Bipolar disorder, hypomanic episode	296.40
412	Bipolar disorder, NOS	296.70

	4.2 Depressive Disorders	
421	Major depression, single episode, unspecified	296.20
422	Major depression, recurrent, unspecified	296.30
423	Dysthymia (or Depressive neurosis)	300.40
424	Affective disorder, depression endogenous	332.00
	4.3 Anxiety Disorders	
431	Panic disorder, without agoraphobia	300.01
432	Generalized anxiety disorder	300.02
433	Organic anxiety disorder	294.80
	5.1 Somatoform Disorders	
511	Somatization disorder	300.81
512	Somatoform pain disorder	307.80
	6.1 Sexual Disorders	
611	Pedophilia	302.20
612	Sexual disorder NOS/Paraphilia NOS	302.90
	7.1 Psychological Factors Affecting Physical Condition	
711	Psychological factors affecting physical condition	316.00
	8.1 Personality Disorders	
811	Antisocial traits, unspecified MD, nonpsychotic	300.90
812	Paranoid personality disorder	301.00
813	Schizotypal personality disorder	301.22
814	Antisocial personality disorder	301.70
815	Personality disorder, mixed features	301.89
816	Personality disorder NOS	301.90
817	Organic personality disorder	310.90

Appendix D

Psychometric Testing Codes

Code	Psychological Test
01	Antisocial Personality Scale The Antisocial Personality Scale is an earlier version of the unpublished Psychopathy Checklist (PCL), (Hare, 1985). It has been stated, though, that there is only a moderate relationship between the PCL and DSM-III diagnosis of Antisocial Personality Disorder (Rogers & Mitchell, 1991).
02	Beck Depression Inventory The Beck Depression Inventory uses symptom rating scales rather than a semi-structured diagnostic instrument. It may be more sensitive to manifestations of depression in lower-class patients (Zigler & Glick, 1986).
03	Beck Hopelessness Scale The Beck Hopelessness Scale is a personality assessment inventory (Drummond, 1992).
04	Benton Visual Retention Test This test measures neuropsychological function specifically, visual construction skills, visual memory, and visual perception. It is effective in discriminating among normal, brain damaged and psychiatric patients (Golden, 1979).
05	Bender Visual Motor Gestalt Test As an objective test, the Bender-Gestalt screens for organic brain dysfunction. As a projective test, it has been used as a nonverbal measure of personality (Hutt, 1985).
06	Booklet Shortened Categories Test The Categories Test is part of the Halstead-Reitan Battery which is a test for the diagnosis of neuropsychogical function (Reitan & Davidson, 1974).
07	Carlson Psychological Survey (CPS) This psychological test is a published psychological test not frequently used.

08 Competency Screening Test (CST)

This fitness test consists of 22 incomplete sentences addressing aspects of the trial and the person's relationship with his or her counsel. The completed sentences are scored from o to 2 based on the response. A score of 20 or less out of 44 "raises a strong index of suspicion" that the person is incompetent to stand trial (Rogers & Mitchell, 1991:103).

09 Draw-A-Man Test

The Draw-A-Man test (also Draw-A-Person) test was initially designed as a measure of intelligence but later expanded to include guidelines for evaluation of personality variables. It is not just the drawing which is evaluated, but the manner in which the person approaches the task. Interpretation focuses on the complete human figure as well as head, hair, facial features, eyes, ears, nose, mouth, neck, arms, hands, legs, feet, and trunk (Groth-Marnat, 1984).

10 Hooper Visual Organization Test

The Hooper was designed as an objectively scored test which could discriminate between people with brain damage and functional disorders. The tasks of this test are sensitive to brain dysfunction and are relatively independent of language and intelligence. "The test consists of 30 items, each of which presents the drawing of a simple object cut into pieces and mixed up. The task of the patient is to visually organize the pieces and name the object" (Golden, 1979:150).

11 House-Tree-Person Test (HTP)

For this test, the person is asked to make a drawing of a house, tree, and person. The person is given an opportunity to describe the drawings and their backgrounds. The interpretation of the drawing of the person is similar to the Draw-A-Person test. The drawing of the tree is related to the person's attitude toward life (e.g., a dead tree "points to emotional emptiness, ... a spiky tree to aggressiveness") (Aiken, 1991:391). Presentation of the house can indicate the person's overall mood. For example, very small houses may indicate withdrawal tendencies or feelings of inadequacy while the presence of a chimney usually indicates psychological warmth and availability (Groth-Marnat, 1984).

12 Luria Nebraska Neuropsychological Battery (LNNB)

The Luria Nebraska Neuropsychological Battery consists of 269 items which measure tactile, visual, and motor functions; receptive and expressive speech; rhythm; memory; intellectual processes; and reading, writing, and arithmetic. It can also be used in extensive neuropsychological screening for brain damage (Aiken, 1991).

13 Memory for Symbols Test
The Memory for Symbols Test and Memory for Words Test are two parts of a complex figure-drawing neuropsychological test.

14 Memory for Words Test
(See Memory for Symbols Test.)

15 Million Clinical Multi-axial Inventory (MCMI)
The MCMI is a personality inventory that contains 175 brief, self-descriptive statements which are to be answered true or false. This test is written at an eighth grade level (Aiken, 1991).

16 Minnesota Multiphasic Inventory (MMPI)
The MMPI is an objective test of personality. "Rather than pointing at a definitive diagnoses, the MMPI allows the psychologist to form a picture of an individual's behaviors, traits, underlying dynamics, level of adjustment, contact with reality, attitude towards the world, and characteristic beliefs" (Golden, 1979:58). The test can also be used to suggest treatment.

17 Multiphasic Sex Inventory (MSI)
This is a relatively new test which evaluates sexual behaviour.

18 Porteus Mazes Test
The Porteus Mazes test consists of a series of 12 mazes arranged in order of increasing difficulty. The examinee is directed to draw the shortest path between the start and finish points without either lifting the pencil or entering blind alleys. "The Porteus is particularly suitable as a brief test for the verbally handicapped ... It is also reported to be sensitive to brain damage, but, as is true of scores on intelligence tests in general, Porteus scores are affected by education and experience" (Aiken, 1991:171).

19 Personality Disorder Questionnaire-Revised (PDQ-R)
The PDQ-R is a test that conforms to the criteria for personality disorders in DSM-III-R.

20 Raven Coloured Progressive Matrices
This test is a "culture-fair" measure of general intelligence. The three factors include simple pattern completion, pattern completion through closure, and analogical reasoning (Haywood & Tzuriel, 1992).

21 Raven Standard Progressive Matrices
This test assesses general intelligence and the ability to form abstractions and coordinate abstract relationships (Haywood & Tzuriel, 1992).

22 Rey Auditory Verbal Learning Test (RAVL)
The RAVL is another test of neuropsychological function.

23 Rey Complex Figure Test
For this test, the patient is required to copy and then reproduce from memory a complex line figure. The figures have no obvious meaning, do not require skilled draftmanship, are sufficiently complicated to call for perceptive, analytical and organizational activity (Schmid-Kitsikis, 1990).

24 Rorschach Test
The Rorschach tests personality function through the use of inkblots. The test is based on the concept that "the way a person produces responses to the inkblots is representative of behavior in similar situations" (Erdberg, 1985:66). The Rorschach may also detect subtle signs of thought disorder that may not be revealed in pencil-and-paper inventory tests (Grisso, 1988b).

25 Shipley Hartford Retreat Scale
The Shipley Hartford Scale is a two-part test that was originally designed to screen for mental retardation in psychiatric patients. It has also been used to diagnose organicity (Golden, 1979).

26 Shipley Institute of Living Scale
The Shipley Institute of Living Scale is a paper-and-pencil inventory that is designed to assess intellectual impairment. This test is not intended for use with mentally disordered or intellectually impaired persons (Andrulis, 1977).

27 Stroop Colour and Word Test
This tool is useful in the diagnosis of brain damage because it is sensitive to most brain injuries and especially sensitive to frontal lobe injuries which may not be detected by neuropsychological tests. Another advantage is that it takes less than five minutes to administer (Golden, 1979).

28 Thematic Apperception Test (TAT)
The TAT is a personality assessment tool that uses pictures, each of which contains a dramatic event or critical situation and a person with whom the examinee can identify. The person is asked to tell a story indicating what the characters have done, are doing, and may do in the future (Dana, 1985).

29 Trail Making Test

The Trail Making Test consists of two parts, each of which consists of 25 circles distributed randomly on a piece of paper. In the first part, there is a number from 1 to 25 written inside each circle, while in the second part, there is a number from 1 to 13 or a letter from A to L written inside each circle. The examinee is required to connect the circles as quickly as possible. This test is effective in discriminating brain injury and normal controls and rules out brain damage in a psychiatric population (Golden, 1979).

30 WAIS-Verbal Subtest

See WAIS-R. The verbal scales test information, comprehension, arithmetic, similarities, digit span, and vocabulary (Kline, 1993). For the Verbal Subtest, the examinee is asked to define 37 words, in order of ascending difficulty. Testing is discontinued if the examinee fails six words in a row. The test was designed to measure knowledge of words, which is highly related to general mental ability (Aiken, 1991).

31 Wechsler Adult Intelligence Scale-Revised (WAIS-R)

The WAIS-R is a test of global intelligence in an adult individual. The test has five performance subtests, which measure visual-spatial abilities, and six verbal subtests, which measure an intellectual, memory factor (Groth-Marnat, 1984). The test yields a Full Scale IQ, a Verbal IQ, and a Performance IQ.

32 Wide Range Achievement Test

This test of school achievement was designed to be an adjunct to tests of intelligence and other psychological characteristics. The three major areas of educational achievement (i.e., reading, spelling, and arithmetic) are tested (Golden, 1979).

33 Wisconsin Card Sorting Test (WCST)

The Wisconsin Card Sorting Test assesses the ability for abstract reasoning and the ability for problem solving. An inefficiency in problem solving may not necessarily be due to poor strategizing or mental disorganization (Taylor & Fletcher, 1990).

34 Word Fluency Test (WFT)

Word fluency tests creative or divergent thinking. This involves the ability to produce a number of words that conform to some letter requirement but that are unrelated semantically. Word fluency is different from ideational fluency which is the ability to produce large numbers of ideas on a particular topic (Kline, 1993).

00	Other
77	Patient refused testing
88	Patient unable to perform test (e.g., illiterate)
99	Unknown

Appendix E

FORENSIC PSYCHIATRIC SERVICES COMMISSION

Research Proposal Submission to the Executive Director
of the Forensic Psychiatric Services Commission

1. Principal Investigator:
   Ms. Denise LaCombe Hitchen
   M.A. (Criminology) Student
   Simon Fraser University

2. Co-Investigator:
   Faye E. Grant

3. Director:

4. Title of Project:
   M.A. Thesis
   Fitness to Stand Trial and Mentally Challenged Defendants:
   Evaluation of the Forensic Process and the Criminal Code

5. Funding:

   5.1 Estimated total funding for the project.
   N/A

   5.2 List all Forensic Psychiatric Services personnel involved, with the estimated time required of each:
   Faye E. Grant, assistance with databases from which subjects will be chosen and research problems that may develop.

   5.3 Indicate any funds, personnel, or resources that will be required from sources other than Forensic Psychiatric Services.
   N/A

6. Project Period: Provide estimate of total time required to complete this project.
   Data collection period: June to September, 1993
   Defended thesis: Spring, 1994

7. Summary of Purposes and Objectives: Including a statement of the potential benefit to Forensic Psychiatric Services and the importance of the proposed research with regard to the research and clinical priorities of Forensic Psychiatric Services.

The purpose of this research is to examine the relationship between mentally challenged (MC) accused persons and fitness to stand trial. Specifically, are MC individuals remanded to a mental health institution for psychiatric evaluation processed different from individuals who are not mentally challenged and yet are remanded for such evaluations? Have the 1992 amendments to the Criminal Code affected the processing MC accused individuals remanded for psychiatric evaluations?

There is a paucity of Canadian literature on the relationship between fitness to stand trial and MC accused persons. This research will determine whether a bias in processing exists, contribute to the existing literature, and form the basis for a prospective study concerning the treatment of MC accused persons remanded for evaluation.

8. Summary of Methodology and Procedures:

Remanded MC accused persons will be compared with remanded non-MC and dual-diagnosed accused persons based on information collected from medical and legal data in subjects' files. There will be no direct contact with subjects included in this study; data gathering is restricted to file information. A coding manual will be used to transcribe file information into a form appropriate for computer analysis. The categories of variables include demographic characteristics of remanded accused, psychiatric and legal histories, and psychiatric assessment information.

9. Description of Population:

9.1 How many subjects will be used?

File data: All MC individuals remanded for psychiatric evaluation in each study year (1985-1986, 1990-1991, 1992-1993) will be included. Dual-diagnosed subjects will be determined by the number of remanded persons clinically diagnosed as both mentally disordered and mentally retarded. The number of subjects in each year's comparison group (non-MC accused) will be 10.

9.2 What are criteria for selection of subjects?

File data: MC, non-MC and dual-diagnosed subjects will be determined by the institution's medical documentation identifying clinical diagnosis.

9.3 How are subjects to be recruited?

File data: No recruitment required.

9.4 If a control group is involved, provide details of the number of subjects, criteria for selection and method of recruitment.

N/A

10. Project Details:

10.1 Where will the project be conducted?
F.P.I., Medical Records Department

10.2 Who will actually conduct the study?
Principal Investigator, Denise LaCombe Hitchen

10.3 Describe how the consent of subjects will be obtained.
N/A

10.4 What is known about the risks and benefits of the proposed research?
There are no risks to subjects.

10.5 What discomfort or incapacity are the subjects likely to experience as a result of the proposed procedures?
N/A

10.6 How much time will be required of a subject?
N/A

10.7 How much time will be required of the control group?
N/A

11. Data:

11.1 Who will have access to the data?
Principal Investigator, Denise LaCombe Hitchen

11.2 Describe how confidentiality of the data will be maintained.
All data will be numerically coded to ensure anonymity and confidentiality.

11.3 What are plans for future use of the data? How and when will the data be destroyed?
There are no future plans for the coded data. After successful thesis defence, coded data sheets will be destroyed.

11.4 Will any data which identifies individuals be available to persons or agencies outside of Forensic Services?
No.

12. Comments:

A request for ethical approval of research will be submitted to the Office of the Vice-President, Research which meets Simon Fraser University's guidelines for research involving human subjects. Members of the SFU Supervisory Committee are Dr. Simon N. Verdun-Jones (Senior Supervisor) and Dr. William G. Glackman of the School of Criminology. The Committee has approved the thesis proposal submitted.

SIGNATURES

_____	_____
Principal Investigator	Director
_____	_____
Date	Date

Co-Investigator:

_____

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, 1993

Ms. Denise Hitchen
Department of Criminology
Simon Fraser University
Burnaby, B. C.
V5A 1S6

Dear Denise:

Thank you for submitting your research proposal on mentally handicapped and fitness to stand trial. I am pleased to tell you that our Research Committee has viewed the proposal favourably and also our Professional Advisory Committee has approved your project.

Could you please contact Mr. Daniel Hawe at the Forensic Institute, 524-7706, and he will arrange for the implementation of your project. I understand that all you require is access to files at the Forensic Psychiatric Institute.

Best wishes for your research.

Yours sincerely,

Dr. Derek Eaves
Executive Commissioner, Clinical Services
Forensic Psychiatric Services Commission

c.c. Daniel Hawe, F.P.I.
c.c. Linda Westfall, Medical Records

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