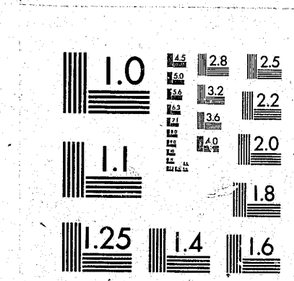

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WORKING PAPERS IN FORENSIC PSYCHIATRY

METROPOLITAN TORONTO FORENSIC SERVICE

METFORS

THE OUTCOME OF FORENSIC ASSESSMENTS:

A STUDY OF REMANDS IN SIX CANADIAN CITIES

R.J. Menzies, C.D. Webster,
B.T. Butler, R.E. Turner

W.P. #19, May, 1980

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ACKNOWLEDGEMENTS

Many people hearing of our study have registered surprise that we were able to complete the research especially since the time for planning was very short. It was not until late May 1978 that we received word that our request to the Department of Justice, Canada, had met with success. In order to meet various deadlines of the Department we had to establish July 1978 as the month for data collection in the six cities. Although preliminary commitments had been given by some key forensic psychiatrists during the course of the previous year, it was necessary to move very rapidly during June 1978. Similarly we had to face a project termination date of 31st March 1979. This meant that the court disposition data had to be collected during February and March of that year. The study was, in short, carried out under considerable pressure from beginning to end.

During the period of formulation some people kindly suggested to us that we would do well to abandon the project in view of the fact that it would be difficult to enlist the full cooperation of all of the principals. Yet with one exception we found it extremely easy to gain the support and help we needed. Why was this so? It might be thought that there was 'something in it' for those who offered their services. If indeed there was 'something in it' for the psychiatrists and the court records officials it was not at a tangible level. No fees were paid to anyone for filling in forms. No meals were bought for participants (in fact, the reverse was the case - the research staff enjoyed considerable private hospitality) and there was no money (or, as it turned out, real need) to fly principals to Toronto in order to meet with us. While the investigators did visit each of the cities at least twice (though often incidentally and in association with other business), most of the communication was by mail.

We mention these administrative details mainly to draw attention to the fact that our colleagues in different parts of the country gave their time and effort. It seems that they were willing to do this partly because they could see clearly the need for such a first venture, partly out of interest to see how the project as a whole would turn out, and partly because they saw it as a duty. Whatever the individual motivations may have been, we would like to acknowledge formally our indebtedness to all the many people who provided help. Everyone who participated provided unfailing courtesy and a singularly professional approach to the task at hand.

To try to mention all the many persons who gave help involves the risk of omitting names. One way of overcoming this difficulty is to avoid listing names. Yet this seems unfair in view of the fact that those listed as investigators actually felt themselves to be enjoined in a collaborative point of research. So some names will be left out. We apologize for this in advance but point out that this paper is but a working draft. Corrections can and will be made in the final version.

In Halifax the project was embraced by Dr. S. Akhtar. Not only were his data exceptionally well organized and clear but he gave us much valuable information about the operation of forensic psychiatric services in Nova Scotia. He also provided dispositions for us. Dr. R. Mishra, the physician at the Halifax County Correctional Centre, gave valuable opinions as did Mrs. Kathleen Waters, Coordinator, Research and Planning, Correctional Services, Department of the Attorney General, Nova Scotia. We were much helped by the excellent unpublished paper 'The Mentally Ill Offender in Nova Scotia' by Mr. Jim Williams and Mrs. Kathleen Waters of the Department of the Attorney General, Nova Scotia. The Halifax psychiatrists as a group deserve a particular note of thanks for responding so ably, promptly, and courteously to a circular letter written by one of us (B. T. Butler).

In Montreal we must single out for particular mention two persons. First, Dr. J. Talbot of the Institut Philippe Pinel de Montréal who not only provided data on a large number of cases but made us aware of the valuable document by Denise Béliveau 'Urgence Psychiatrique et Intervention Policière, Communauté Urbaine de Montréal'. Dr. Talbot did more than worry about his own data - he was very helpful in ensuring that his colleagues were informed about the study. He grasped our purpose quickly and went to much trouble on our behalf. Second, M. G. Martin, Chef de la Division de Développement, Service de l'Informatique, Ministère de la Justice, Gouvernement du Québec, for putting his computerized record keeping system at our disposal and for giving us his personal attention throughout. He deserves credit not only for showing us how court records can be kept but for employing his Department's excellent system on our behalf.

Others in Montréal were also extremely helpful. Dr. L. Béliveau, Directeur Général, Institut Philippe Pinel de Montréal, in an early interview gave us his blessing and support. Mme. Ginette Racine, a.m.a., Responsable des Archives Médicales, at the Institut was always ready to search records on our behalf. Her staff deserve much credit. Dr. B. Cormier, Forensic Clinic, McGill University, not only filled in forms but twice gave two of the investigators (C.D.W. and R.J.M.) the benefit of his exceptional scholarship. In addition we thank Drs. P. Laberge, A. Mauffette, J. Wolwertz and G. Paul-Hus. Dr. Claude Morand kindly spent time explaining his research programme to one of us (C.D.W.).

Although the bulk of Metropolitan Toronto residents are sent to METFORS for assessment, some go to other institutions. This being so we had to enlist the support of colleagues in related agencies. Dr. R. Fleming of the Penetanguishene Mental Health Centre filled in his share of forms as did Drs. G. Heasman, S. Hucker, B. Orchard and W. Hill of the Clarke Institute

of Psychiatry. Dr. G. Cooper, in private practice, also kindly worked with us. The Queen Street Mental Health Centre, as always was ably represented by Dr. I. Wayne. Most easy to overlook of us would be our hard-working colleagues at METFORS, Drs. D. Byers, F. Jensen, and R. Mahabir.

On the court side in Toronto we were as usual helped by Mr. A. Kostecka and his records staff under the general guidance of the Chief Judge of the Criminal Court Division, His Honour Judge F. Hayes. Our colleague, Mrs. Margaret Jackson kindly organized the Toronto dispositions for us. But she could not have done this without the help of Mr. B. Beckman of the Metropolitan Toronto Police Service. We have been fortunate indeed to have Mr. Beckman's help not only in this study but in others.

In Calgary we were under the wing of Dr. J. Arboleda-Florez, Director of the Forensic Unit at the Calgary General Hospital. He not only himself provided data but put the services of his organization fully at our disposal. Dr. Morris Carnat deserves particular mention since he does most of the initial assessments for the court, and, as a result, had to complete many forms. During the second phase, collecting dispositions, we were given good general advice by Mr. John J. McGurran, Health Care Evaluator, Forensic Unit, Calgary General Hospital. In the Records Office itself we were given much generous help by Mrs. Doris Lebel, Acting Court Administrator, Provincial Court of Alberta and Mr. K. W. Hills, Chief Clerk, Calgary Remand Centre.

Dr. J. Duffy, Executive Director of Forensic Psychiatric Services, British Columbia, made our task in B. C. very easy. Since forensic psychiatric services are centralized in that province and since, from the very outset, he opted to work strongly in support of the project, we were able to cover ground quickly. This was particularly the case because Dr. D. Eaves also became closely involved in the work and set aside much valuable time to talk with one

of us (C.D.W.). His leadership was crucial to us. It was, though, Dr. R. Whitman who did most of the actual filling in of forms. Like Dr. Carnat in Calgary, Dr. Whitman does the bulk of the initial assessment work for the Clinic and, as a result, saw many cases during July. Dr. Whitman also spent time with us helping us to gain an appreciation of the assessment process in Vancouver. Others who participated were Drs. Kontaxopoulos, Mel Diili, Stephenson and Vallance. To them we are most grateful.

As well as those who provided data, others in Vancouver deserve a note of thanks. From the Headquarters of Forensic Psychiatric Services we are grateful to Mrs. S. Baird, Education Coordinator, and Mr. A. H. Ryan, Court Liason Officer. Both kindly gave full descriptions of their programmes (not though, specifically mentioned in the particular report). Dr. A. Marcus, Head, Forensic Psychiatric Services, Department of Psychiatry, University of British Columbia outlined to us his involvement and interests in forensic psychiatry.

Records at the Forensic Psychiatric Institute are under the firm control of Mrs. Marien McNeal. Not only was Mrs. McNeal able to provide us with exactly the information we needed but, as well, she allowed us access to her detailed statistical summaries. From her we learned how record-keeping and research can be and must be combined in an integral way. Her work could provide a ready-made blueprint for record keeping in Canadian forensic psychiatry (especially if combined with a version of the court recording system directed by M. Guy Martin, mentioned above). When we arrived in Vancouver in March 1979, the task of obtaining dispositions seemed formidable. We had the in-patient dispositions from Mrs. McNeal but the others we knew would be hard to trace. Fortunately, Ms. Pamela Musgrove of the Provincial Court Records office came to our rescue and provided all the help and attention we could have wished.

In Victoria we were assisted most ably by three persons in the Forensic Clinic. Dr. K. McLeod early agreed to cooperate and gave us his full backing. Dr. W. Forrester filled in forms and consented to be interviewed. Mrs. B. Payne looked after the paperwork and was kind enough to trace dispositions. One of us (C.D.W.) had a most informative interview with Dr. W. Billung-Meyer and we learned how his practice complements that of the Forensic Clinic. Mr. B. L. Sutton of the Vancouver Island Regional Correctional Centre showed patience with us and gave much useful general information about the conduct of psychiatric assessments in person. Dr. J. E. Boulding, Psychiatrist, and Mr. Ted Beaubier, Crown Counsel, gave clear accounts of Court-Clinic relations in Nanaimo.

The investigators also wish to thank those who gave administrative support. Professor G. A. B. Watson, Director of the Centre of Criminology, University of Toronto helped to negotiate the contract and was a constant source of advice and support. Mrs. Rita Donelan of the Centre helped the project in numerous ways and Miss Elizabeth Burgess not only worked hard on the details of our financial expenditures but gave good counsel on how best to allot our resources. Mr. M. Phillips, Deputy Director-Administration, METFORS, went to considerable lengths to ensure that we had a good working environment and that, when necessary, rules were bent in our favour.

Mr. N. Avison of the Department of Justice, Canada, wrote the document that inspired this study and the related projects. In addition to his many other duties, he served as our project officer and dealt promptly and effectively with our various requests. His support was unstinting and his interest unflagging.

We are grateful to several people who kindly commented on an earlier draft: Dr. Akhtar, Dr. R. Chalke, Dr. G. Heasman, Dr. M. Preusse, and Dr. V. Quinsey.

ABSTRACT

This article summarizes data collected from 248 pretrial cases assessed by forensic psychiatrists for the criminal courts in six Canadian cities during July, 1978. The discussion focuses upon: purposes for court referrals, statutes employed for psychiatric remands, characteristics of forensic patients, diagnoses and recommendations rendered by clinicians, and the relationship between psychiatric recommendation and judicial outcome. It is suggested that legal and policy analysis of Canadian forensic assessment is to date lacking in detail and comprehensiveness, and that research needs to be directed more towards decision-making and referral practices of the courts.

THE OUTCOME OF FORENSIC PSYCHIATRIC ASSESSMENT: A STUDY OF REMANDS IN SIX CANADIAN CITIES

R.J. Menzies, C.D. Webster, B.T. Butler, R.E. Turner

The physical and mental presence of accused persons is considered an integral component of our criminal trial process. "Since the mid-seventeenth century, the common-law rule has been that one cannot be required to plead to an indictment or stand trial when so disordered as to be incapable of putting forth a 'rational' defence" (Slovenko, 1977, p.166). To this end, Western legal systems have developed formal procedures for enlisting the expertise of psychiatric professionals, in evaluating the fitness of criminal defendants to undergo the rigors of the adversarial trial.

The court-ordered psychiatric remand in the past two decades has become the focus of a number of controversies involving the complex interpenetration of the legal and psychiatric professions. In particular, the more strident critics suggest that the fitness remand may in fact impede the accused person's rights to fair adjudication, and that "psychiatrists ... are consistently being seduced into expressing opinions on issues quite beyond their field of competence" (Schiffer, 1978, p.216). Geller and Lister (1978) express concern over social control elements of the assessment, in that persons may be referred to psychiatrists in order to control social deviance (Clausen and Yarrow, 1955), to limit presumed violent behavior (Rubin, 1972), to provide preventative detention (Goldstein, 1968), to institute

legal strategies (Cooke, Johnston, and Pogany, 1973), and to manage the unmanageable when other legal means have failed (Slovenko, 1964). In the American context, several articles have pointed to the potential unconstitutional nature of the remand as an abrogation of protection against self-incrimination (Danforth, 1965; Pollack, 1970).

To a considerable degree, attacks on the forensic assessment have been a spill-over from the general literature condemning the clinican as "psychocop" (Kunjukrishnan, 1979), "conservative agent of social control" (Steadman, 1973), and even "fascist" (Torrey, 1975). As scientists, we should be prepared to separate evidence from ideology, and certainly the abundance of antipsychiatric literature is largely unimpeded by data. In fact, the forensic assessment by its very nature is not readily anemable to empirical investigation. Psychiatric decision making in the criminal context is an example of low-visibility, discretionary justice (Davis, 1969; Kadish & Kadish, 1973). Wide discrepencies may prevail between the written law, and application of that law in the clinic and courtroom (Pfohl, 1978; Roesch, 1978; Stone, 1978). While European and North American journals have recently published increasing numbers of reports on court-ordered remands, in fact "the jury is still out" concerning the crucial legal, medical and ethical issues.

CANADIAN LEGISLATION PERTAINING TO PRE-TRIAL ASSESSMENTS:

The Canadian Criminal Code (Martin's Annual Criminal Code, 1979) provides for pretrial psychiatric assessment under Sections 465(1)c,

465(2)a and b, 543(1) and (2), 608(1) and (2) (court of appeal), and 738(5) (summary conviction court). In addition, provincial mental health acts contain psychiatric remand legislation (for example, Sections 14(1) and 15(1) of the Ontario Act). The overlapping of the federal and provincial law results in "some rather complex statutory machinery" (Schiffer, 1978, p.51), and almost certainly contributes to regional differences in the operationalization of the statutes.

The Law Reform Commission of Canada expresses dissatisfaction with the present structure of the law:

> The sections of the Code dealing with the mentally ill offender are poorly organized and articulated ... it is important that the legislative language be rationalized and clarified to clearly (sic) articulate and differentiate between (sic) the various legal concepts and procedures affecting mental disorder in the criminal law. (Law Reform Commission of Canada, 1976, p.5)

The legislation on forensic assessment is singularly deficient in the following areas: 1. Criteria for the unfitness of the accused; 2. Guidelines for the conduct of fitness hearings; 3. Expression of the variety of remand possibilities; 4. Specification for a report to be forwarded to the judge; 5. A legal framework for the conduct of the fitness procedure.

The Commission recommends that "[r]emands for examination of accused offenders suspected of being mentally disordered should be made under the Criminal Code" (Law Reform Commission of Canada, 1976, p.32-3).

THE PSYCHIATRIC ASSESSMENT IN CANADA:

There is a small but bourgeoning literature on court-ordered psychiatric examinations in the Canadian context. Previous research has been conducted in Nova Scotia (Akhtar, 1971, Jobson, 1969), Montreal (Schlatter, 1972), Ontario (Greenland and Rosenblatt, 1972), Ottawa (Arboleda-Florez, Gupta and Alcock, 1975), Toronto (Jackson, 1978, unpublished; Menzies, Webster, Butler, et al, 1979; Turner and Jerry, 1962; Watson, Rich and Gray, 1957), and Saskatchewan (Kunjukrishnan, 1979). The evidence points to wide variations in the style and content of assessments among different jurisdictions and services. Such factors as: referral patterns by courts; characteristics of patient populations; composition of clinical staff; availability of evaluative, treatment and research facilities; and communication patterns with the judicial system, are all contributory to the nature of evaluations delivered by forensic psychiatrists.

The present study involves an examination of psychiatric remands conducted in six Canadian municipalities. The research represents the first comprehensive attempt to compare and contrast forensic assessments across different Canadian jurisdictions. Before genuinely informed law reform can proceed in the medico-legal context, it is imperative that we build our policy efforts upon solidly empirical foundations. More specifically, in this article we wish to examine such matters as: 1. Patterns of assessment, and relevant legislation employed by the courts; 2. Demographic characteristics of court-

referred forensic patients; 3. Legal and psychiatric histories of the assessment clientele; 4. Decision-making by clinicians; 5. Impact of psychiatric recommendations upon judicial outcome.

METHOD

The instrument of research was a single-paged summary sheet completed by participating psychiatrists at the conclusion of each court-referred assessment.1 This instrument schedule was designed over the course of several months through use in the Brief Assessment Unit of the Metropolitan Toronto Forensic Service. It was constructed in order to collect economically a large variety of background, epidemiological, judgmental, and outcome variables on court-referred cases in six Canadian cities during the month of July, 1978.

Prior to the beginning of July, researchers solicited the co-operation of 29 psychiatrists in Victoria, Vancouver, Calgary, Toronto, Montreal, and Halifax. Every effort was made to ensure that we did not "miss" any psychiatrist likely to complete assessments on behalf of the courts. No psychiatrist refused cooperation. The researchers were able to meet most of the participants before the study began. Participants were supplied with an instruction manual on the completion of forms; an effort was made to establish consistency of concepts and variables (for example, ICDA-8 was employed as a diagnostic guideline).

Psychiatrists supplied data on all adults assessed on pre-trial or pre-sentence remand from July 1 to July 31, 1978. Juvenile cases,

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1. Copies of the instrument schedule are available from the authors at METFORS, 999 Queen Street West, Toronto, Canada, M6J 1H4.

post-sentence assessments, civil commitment hearings, and referrals from the penal system were excluded from the sample pool.

The resulting data base consisted of 248 cases. During the following eighteen months, researchers, with the co-operation of participating psychiatrists, collected court-dispositions and follow-ups of the patient sample. Data were tabulated, coded, transferred to computer cards, and processed through the S.P.S.S. services (Statistical Package for the Social Sciences) of the University of Toronto.

PURPOSES FOR COURT REFERRALS

A frequent criticism of the forensic assessment involves the "grossly inadequate communication ... between ... courts and psychiatrists" (Bendt, Balcanoff and Tragellis, 1966, p.312), and that "different judges may have different questions in mind which they would like the psychiatrist to examine in detail" (Akhtar, 1971, p.6). Indeed, in the present study participants frequently expressed concern that, since assessments were often conducted in the absence of clear questions from the Court, psychiatric resources were not being effectively utilized. The forensic assessment is only as successful as the judge's ability selectively and accurately to engage the clinician. In the present study, a full 82 percent of patients were referred from the Court or the Crown. Yet, studies have demonstrated that judges vary in their referral practices (Bohmer, 1976; Sparks, 1966). Schiffer, citing work by Hogarth (1971) says:

> In actual practice, judicial use of the psychiatric remand procedures seems to depend upon the personality of the sentencing judge as much as upon the offender.
> (Schiffer, 1978, p.228)

One English study (Gibbens, Soothill & Pope, 1977) found that a full forty percent of magistrates gave no reason for the remand. Again, psychiatrists in the present study, were unclear regarding the identity of the party who actually initiated the referral, in addition to the relevant issues (fitness, dangerousness, suitability for bail, dispositional recommendations, etc.) to be addressed in letters to the Court. As Stone suggests:

> ... the major element in the continuing abuse of competency to stand trial is the discretionary practices of the judiciary ... Constrained by inadequate resources, grappling with a responsibility that cannot be fulfilled, judges are harassed administrators desperate for acceptable dispositions in a system that does not provide them.
> (Stone, 1978, p.62-63)

REFERRAL METHODS AND STATUTES EMPLOYED

Table 1 presents a summary of cases tabulated by city and method of assessment. From the evidence, there is approximately a three-to-one

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INSERT TABLE 1 HERE

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ratio between non-hospitalized and hospitalized patients receiving forensic assessments. The appropriateness of this proportion of inpatients is subject to debate; we simply reiterate the Law Reform Commission's proviso that "extreme caution should be exercised before there is any deprivation of personal liberty in the form of psychiatric examinations or treatment (Law Reform Commission of Canada, 1976).

The relative employment of federal and provincial legislation appears to be changing over time. As recently as 1972, Greenland and Rosenblatt reported that only five percent of patients were referred under the ambit of the federal Code; the majority were Mental Health Act remands (Greenland & Rosenblatt, 1972). But by 1978, Schiffer observed that "it seems that the Code is more frequently selected [than the Act] in Ontario" (Schiffer, 1978). The present study reveals a large movement towards use of the Criminal Code provisions. Only two cases each in Toronto and Vancouver involved provincial legislation. It would appear that the Commission's recommendation (Law Reform Commission of Canada, 1976) for the exclusive employment of the Code has been largely implemented in practice if not statutorily.

DEMOGRAPHIC, JUDICIAL AND PSYCHIATRIC DATA

While the forensic assessment population is a heterogeneous group, an examination of background, psychiatric, and legal characteristics produces a fairly consistent profile of the "typical" patient.

Of 248 cases, 228 (91.9 percent) were males and 20 (8.1 percent) were females. Nineteen percent of patients were under the age of twenty, 40 percent were twenty to twenty-nine, 23 percent were from thirty to thirty-nine years of age, and 18 percent were forty years or older. Only 34 individuals (14.9 percent) were married at the time of

assessment; a further 14 (6.1 percent) were living common-law. The majority (137, or 60.1 percent) were separated, widowed or divorced.

Persons on remand were mostly laborers or blue collar workers (109, or 48.7 percent), or unemployed (83, or 37.1 percent). A small proportion were students (15, or 16.7 percent), managers and professionals (9, or 4.0 percent), and white collar workers (8, or 3.6 percent).

The educational history of patients was characteristically low. Of 200 cases for which data were available: 73 (36.5 percent) had grade 8 or less, 60 (30.0 percent) completed grade 9 or 10, 47 (23.5 percent) had grade 11 to 13 education, and 20 (10.0 percent) gained at least some post-secondary education.

Canada was the country of origin for 206 (84.8 percent); 29 (11.9 percent) were born in Europe; the remainder were from the United States (3 or 1.2 percent), or elsewhere (5, or 2.1 percent).

Table 2 presents a summary of criminal history and epidemiological data, tabulated by city.

INSERT TABLE 2 HERE

Convictions for property offences had previously been recorded against 117 patients (54.2 percent); the proportion with violence convictions

was somewhat lower (74, or 36 percent). Slightly over a third of persons had previously spent time in prison, and 103 (or 42.9 percent) were at the time of study charged with a crime of violence. Inter-city variation was considerable. In particular, the Montreal sample exhibited a less extensive criminal background than the other cities. Only one in ten Montreal patients, for example, had prior convictions for offences against the person, whereas the corresponding rate in Vancouver was over one-half.

Overall, somewhat less than one-half of patients were excessive consumers of alcohol, and one in four were extensive drug users.

Of the persons assessed, 116 (51.5 percent) had previous inpatient psychiatric experience. This finding is in close conformity to data from previous Canadian studies, showing, respectively, 47 percent (Greenland & Rosenblatt, 1972) and 58 percent (Kunjukrishnan, 1979) of patients to have undergone prior hospitalization for psychiatric reasons.

DIAGNOSIS

Psychiatrists indicated their primary diagnosis of patients, according to the taxonomy of ICDA-8. Findings are summarized in Table 3. It is

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INSERT TABLE 3 HERE

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noteworthy that 39.4 percent of patients were diagnosed as psychotic, whereas only 4 percent exited from the assessment process without a

psychiatric label. Subjects on remand from courts are apparently perceived on the whole as quite ill. Schiffer suggests that, in fact, psychiatrists may be overestimating mental abnormality in offender populations (Schiffer, 1978). This observation is reminiscent of Scheff's labelling theory (Scheff, 1966, 1975), and is particularly discomfiting when juxtaposed against Scott's contention that "In those cases selected for psychiatric report a classical diagnosis cannot be made in more than 20 percent. In the other 80 percent it is impossible to attach a label any more accurate than 'personality disorder' or 'overt maladjustment' (Scott, 1953, p.93).

FITNESS TO STAND TRIAL

The fitness of the patient to stand trial is the only issue in the psychiatric remand to which the statutes give expression. Still, as the Law Reform Commission, inter alia, indicates, specific criteria for findings of fitness are mostly characterized by their absence. The Chalke Committee (1969) has suggested uniform criteria for evaluating fitness, Robey (1965) has designed a summary sheet in the American context and Roesch (1977) has evaluated and constructed actuarial devices for competency findings. The Law Reform Commission recommends that a person be found unfit if, owing to mental disorder: 1. he does not understand the nature or object of the proceedings against him, or, 2. he does not understand the personal import of the proceedings, or, 3. he is unable to communicate with counsel (1976, p.14).

Nevertheless, our knowledge of the dynamics of findings of fitness is generally limited to proportions of fit patients. For example, in the present research 84.7 percent of persons were found fit (compared to other Canadian studies ranging from 65 percent (Arboleda-Florez, Gupta & Alcock, 1975) to 93 percent (Kunjukrishnan, 1979)). One additional finding is that psychiatrists are sensitive to the differentiation between mental disorder and unfitness; that is, "... psychiatrists are reluctant to equate abnormality with unfitness - though abnormality among remand cases may be common, unfitness is rare" (Schiffer, 1978, p.57). Figure 1, extracted from the present data, compares numbers of abnormal and unfit persons, and substantiates Schiffer's comment.

INSERT FIGURE 1 HERE

DANGEROUSNESS

The body of literature on psychiatric predictions of dangerousness is legion; the consensus attests to the inability of psychiatrists to predict dangerousness with any degree of scientific acumen. As Sturup said, "Little is known ... about assessing dangerousness beyond intuitive feelings and general statistics that cover certain types of offenders" (Sturup, 1968, p.17-18).

Despite the well-documented case against the evaluation of dangerousness by clinicians, it remains an issue which is commonly delegated to

the forensic psychiatrist by the courts. In the context of the mental status remand, the element of "danger" is tangentially a factor in at least four decision areas: (1) amenability for bail on conditional release; (2) necessity for a custodial setting; (3) possibility of involuntary hospital admission under the provincial Mental Health Act; (4) general recommendations to the court regarding preferred sentencing policy, suitability for treatment, etc.

In the present study, participant psychiatrists were required to respond to a forced-choice "yes" or "no" series on two axes of dangerousness: present-future and self-other. Overall, the following results were obtained:

Dangerous self present	-	12.1 percent
Dangerous others present	-	19.8 percent
Dangerous self future	-	21.4 percent
Dangerous others future	-	35.8 percent

This finding is augmented by a recent context analysis of letters to judges, wherein 24.1 percent of psychiatrists' communications to the court contained reference to the patient's dangerousness (Henderson, 1980, unpublished). Again, the present study demonstrated large inter-city differences. In Figure 2, Toronto psychiatrists were not likely to perceive their clients as dangerous, while Montreal clinicians were most optimistic in their appraisals.

INSERT FIGURE 2 HERE

RECOMMENDATION AND DISPOSITION

Psychiatrists in the six Canadian municipalities recorded their recommendations for the disposition of patients as follows:

INSERT TABLE 4 HERE

The plurality of recommendations are of a medical rather than judicial nature. It is noteworthy, still, that in 14 percent of cases psychiatrists recommended a penal setting. Also, the "no recommendation" percentage of 14.3 percent is low in comparison to Kunjukrishnan's finding of 44 percent (1979). The recent context analysis of letters to the court, mentioned above, found that 19.3 percent of letters contained recommendations concerning judicial disposition, whereas 52.2 percent referred to treatment recommendations (Henderson, 1980, unpublished).

In the six cities, 185 of 248 ultimate dispositions of the cases were retrieved (74.6 percent). Medical and judicial dispositions distributed according to the data shown in Table 5:

INSERT TABLE 5 HERE

The percentage of individuals ultimately transferred to hospital, provides an index of the real diversionary function of the psychiatric remand. In this study, 13.5 percent of individuals were eventually hospitalized. The remainder were returned to court, and either convicted (73.5 percent) or acquitted (13.0 percent).

The next research question involves the extent to which there exists a relationship between the psychiatrist's recommendation and the court's disposition. This issue has been addressed rather sparingly in the literature, and includes studies in the United States (Bohmer, 1976; Geller & Lister, 1978), Great Britain (Binns, Carlisle, Nimmo et al, 1969; Faulk & Trafford, 1975; Prins, 1976; Sparks, 1966), and Canada (Arboleda-Florez, Gupta & Alcock, 1975; Greenland & Rosenblatt, 1972; Jackson, 1978, unpublished; Jobson, 1969; Watson, Rich & Gray, 1957).

It is important to underscore the limitations and methodological flaws of recommendation-disposition studies. First, to paraphrase Jackson (1978, unpublished), psychiatric recommendations are often nebulous, unquantifiable, or non-existent. Second, it is highly problematic, both ethically and legally, whether forensic psychiatrists should invoke recommendations concerning such essentially judicial issues as fitness for bail, necessity of custodial setting, and dangerousness. Third, certain forms of psychiatric recommendations - e.g., "immediate certification" - result not in judicial dispositions, but rather in the judge's endorsement of dispositional decisions which are effected by the psychiatrist himself. Fourth, as Bohmer (1976) points out, in the absence of information regarding the actual employment of psychiatric reports by judges, it remains impossible to clarify the relationship between recommendation and disposition as either spurious or real.

Having noted these limitations, we present in Table 6 a crosstabulation, from the data, of psychiatric recommendation and ultimate disposition of the case. Cases are analyzed only for the three recommendations for custodial confinement, hospitalization, and outpatient care.

INSERT TABLE 6 HERE

Greenland and Rosenblatt (1972) in their study of Ontario inpatient assessments, discovered an interaction between the degree of restriction of liberty implied in the recommendation, and the judge's willingness to conform to the recommendation. The data in Table 6 seem to corroborate this suggestion. For example, when the psychiatrist recommended a custodial setting, in 73 percent of cases the person was incarcerated. Recommendations for hospitalization were observed in 59 percent of cases (although in this instance the decision is not necessarily within the jurisdiction of the judge). Finally, accused persons recommended for outpatient care received probation in 55.4 percent of cases (but were more likely than others to be acquitted or have their charges withdrawn).

While these figures demonstrate that judges are taking psychiatrists' recommendations into account to some extent, or at least that accused persons are being perceived in similar manners by both systems - we are nevertheless struck by the general lack of communication between clinic and court. Not only do clinicians often effect their decisions

within a legal vacuum, but also there are no guidelines for psychiatrists' letters, no set policy regarding disclosure to both defence and Crown, no legal status for the report, and only in isolated jurisdictions are there entrenched mechanisms for informing psychiatrists concerning the judicial results of their medical efforts. As Woodside states, "Failures of communication still occur ... Such difficulties understandably arise when both court and hospital work under pressure, and no separate department exists to collate, monitor and advise on all medico-legal cases" (Woodside, 1976, p.33).

CONCLUSION

Canadian systems of pretrial psychiatric remands are hardly the Draconian psychocourts suggested by Szaszian polemics. Neither are they in all cases very secure repositories of social justice for mentally disordered persons confronting the legal system. As we have shown, law, policies and procedures vary considerably across Canadian jurisdictions. Attempts to centralize and regulate the law, and to reformulate processes of psychiatric assessments, must commence with more general evaluations of the relationship between the medical and legal professions. Psychiatrists are of greatest service to the criminal justice system when they function as screening agents rather than as substitutes for judicial decision-makers. The attention of policy and research to date has focussed mostly on the activities of clinicians, and has largely neglected the practices of the courts in enlisting the services of medical experts. Only through a more

balanced perspective will we be capable of differentiating accurately between individuals best processed through the criminal justice system and persons in need of diversion into mental health facilities.

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TABLE 1

NUMBER OF CASES ACCORDING TO METHOD OF ASSESSMENT

Type of Assessment	CITY						TOTAL
	Vancouver	Calgary	Toronto	Montreal	Halifax	Victoria	
Inpatient	11	5	23	13	6	0[2]	58
Outpatient	2	0	12	5	0	2	21
Brief/ Mental at Gaol 1	41	18	66	36	0	6	167
TOTAL	54	23	101	54	6	8	246

1. 'Mental at Gaol' is a term stamped on the documents of individuals remanded for brief assessment by courts in Toronto.

2. No inpatient facilities exist in Victoria.

TABLE 2

PATIENT BACKGROUND

CITY

PATIENT BACKGROUND	Victoria		Vancouver		Calgary		Toronto		Montreal		Halifax		TOTAL		Missing Observations
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	
Previous Convictions Property Offences	3	42.9	29	63.0	8	40.0	56	58.9	16	38.1	5	83.3	117	54.2	32
Previous Convictions Offences vs. Person	2	28.6	25	54.3	6	30.0	34	37.4	4	9.5	3	50.0	74	34.9	36
Previous Time in Prison	2	28.6	16	39.0	5	25.0	36	37.5	9	22.0	4	66.7	72	34.1	37
Presently Charged With Crime of Violence	4	50.0	22	43.1	11	57.9	47	46.5	16	29.1	3	50.0	103	42.9	8
Previous Outpatient Psychiatric Experience	4	50.0	34	69.4	13	68.4	62	62.6	24	58.5	2	40.0	139	62.9	27
Previous Inpatient Psychiatric Hospitalization	1	12.5	32	65.3	12	54.5	45	45.5	24	55.8	2	33.3	116	51.1	21
Excessive Use of Alcohol	4	50.0	23	48.9	4	20.0	53	55.8	13	31.0	5	83.3	102	46.8	30
Excessive Use of Drugs	3	37.5	6	13.3	1	5.3	33	34.7	9	21.4	4	80.0	56	26.2	34

TABLE 3

PRIMARY DIAGNOSIS

	Psychosis	Personality Character Disorder	Alcohol Drug Related	Neurosis Reactive Transitory	Sexual	Mental Retar-dation	No Diag-nosis	TOTAL
Number	89	61	31	16	10	10	9	226
Percent	39.4	27.0	13.7	7.1	4.4	4.4	4.0	100.0

Missing Observations = 22

TABLE 4

PSYCHIATRISTS' RECOMMENDATIONS

	Outpatient Care	Psychi-atric Hospital	Custodial Setting	Further Analysis Inpatient	No Recomm. Return to Court	TOTAL
Number	90	47	32	23	32	224
Percent	40.2	21.0	14.3	10.3	14.3	100.1

No Data N = 24

TABLE 5

DISPOSITIONS

	Psychiatric Hospital	Penitentiary	Gaol/Reformatory [1]	Probation	Fine	Acquit Withdrawn Released	Deported	TOTAL
Number	25 [2]	14	55 [3]	63 [4]	3	24	1	185
Percent	13.5	7.6	29.7	34.1	1.6	13.0	0.5	100.0

1. i.e., less than 2 years
2. Including both Warrents of the Lieutentant Governor subsequent to findings of unfitness and certification under Provincial Act.
3. Dual sentence gaol/probation or gaol/fine was recorded as "gaol".
4. Dual sentence probation/fine was recorded as "probation".

TABLE 6

RELATIONSHIP BETWEEN RECOMMENDATION AND DISPOSITION

DISPOSITION	RECOMMENDATION: Correctional-Custodial Setting		Hospitalization		Outpatient Care		TOTAL	
	#	%	#	%	#	%	#	%
Penitentiary	3	11.5	0	0.0	3	4.6	6	4.8
Gaol/Reformatory	16	61.5	4	11.7	15	23.1	35	28.0
Hospital	1	3.8	20	58.8	2	3.1	23	18.4
Probation-Fine	4	15.4	7	20.6	36	55.4	47	37.6
Acquittal-Release-Withdrawn	2	7.7	3	8.8	9	13.9	14	11.2
TOTAL	26	100.1	34	99.9	65	100.1	125	100.0

Not included in analysis:

1. No recommendation (return to Court only) N = 27
2. Recommendation for further analysis inpatient N = 16
3. Disposition of Deportation N = 1
4. No information (either recommendation or disposition) N = 79

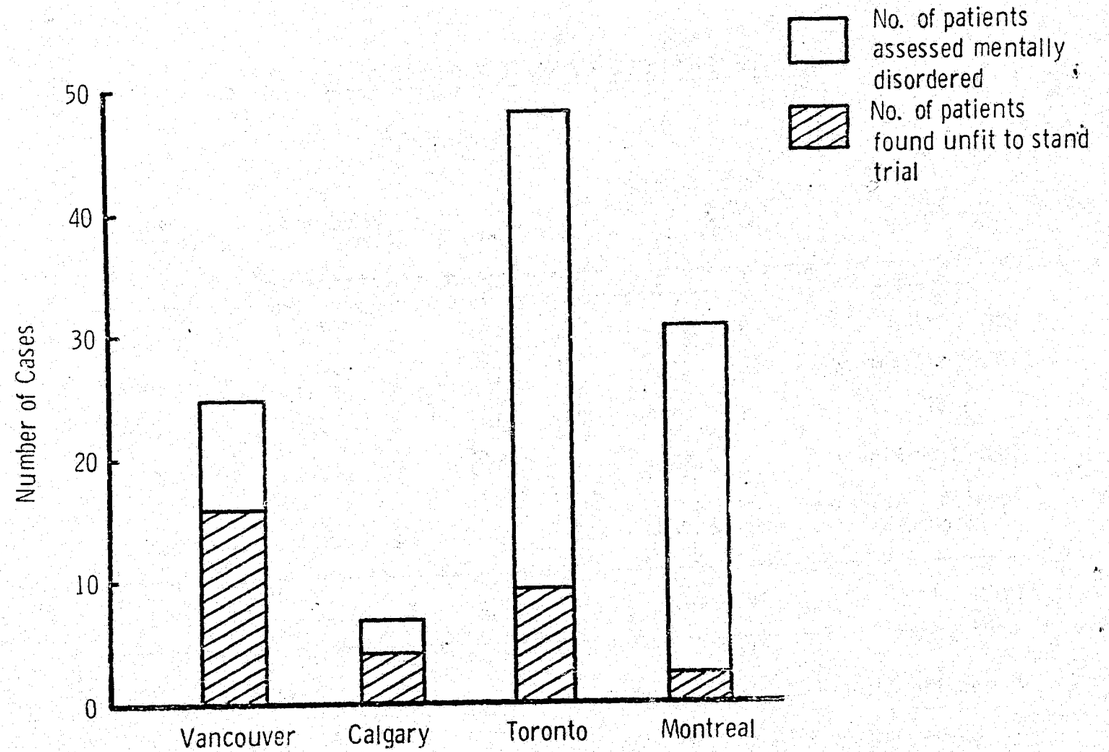

Figure 1: Percent persons found mentally disordered and unfit to stand trial by city.

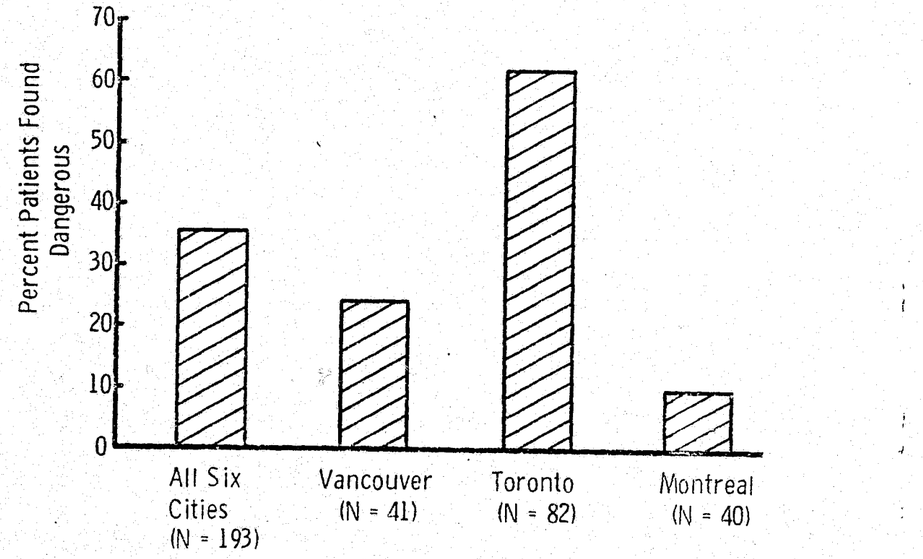

Figure 2: Percent persons considered likely to be dangerous to others in the future by city.

END