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Special Study on Mentally Disordered Accused and the Criminal Justice System

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Special Study on Mentally Disordered Accused in the Criminal Justice System

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r revised

x suppressed to meet the confidentiality requirements of the Statistics Act

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F too unreliable to be published

Preface

The Canadian Centre for Justice Statistics (CCJS) is the focal point of a federal-provincial-territorial initiative dedicated to the production of national statistics and information on the justice system in Canada. This information includes data on court caseloads, characteristics of cases and persons moving through the court system, resources used in the operation of courts and provision of legal aid and criminal prosecution services.

The CCJS courts staff would like to thank everyone within the National Justice Statistics Initiative as well as review boards and members of the health community who contributed to the information and expertise necessary to make this report possible.

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Table of contents

Highlights

- The relationship between the court system and the health care system in addressing persons found unfit to stand trial and not criminally responsible on account of mental disorder has evolved over the past two decades alongside law and policy changes.

- With the increasing availability of psychotropic medication and improvements in psychiatric diagnosis over the past three decades, mental health care facilities have progressively shifted the treatment of mentally ill persons from complete institutionalisation to a less restrictive environment within the community.

- Changes in law and policy relating to mentally disordered accused have precipitated the need to examine the feasibility of new data collection possibilities.

- The process of determining whether an accused is unfit to stand trial and/or not criminally responsible on account of mental disorder can involve the court system, the review board of the jurisdiction and possibly the health care system.

- The review boards, mandated by the Criminal Code, are now responsible for overseeing most dispositions and treatments administered to mentally disordered accused.

- It may be possible to capture additional information beyond basic counts of accused who are found unfit to stand trial and not criminally responsible on account of mental disorder in the court system, including:
  – referrals to the review boards
  – treatment orders and conditional discharges for persons found unfit
  – dispositions for found not criminally responsible on account of mental disorder
  – time frames for assessment and treatment of persons found unfit to stand trial

- Persons found not criminally responsible on account of mental disorder may not appear before a review board if the court issues an absolute discharge upon the finding.

- Data collection addressing mentally disordered accused would be enriched by expanding research to include the following areas identified through interviews with health professionals:
  – review board information
  – psychological or psychiatric history of the accused
  – most responsible diagnosis of the accused's mental disorder
  – health care facilities
  – detention facilities
  – remand centres

1. Introduction

This paper represents the first part of a Special Study geared toward examining mentally disordered persons who come into contact with the justice system. The objective of the study is to examine how developments both in mental health care and in the justice system's policies over the past two decades have affected the need for and feasibility of data collection relating to mentally disordered accused in the court system. The relationship between the health and justice sectors in regards to this group has evolved alongside changes in law and policy. This paper is intended to provide background information for possible data collection initiatives and future research addressing the interplay between the health and justice systems when a mental disorder becomes a factor in legal proceedings. The second part of this study will be a study addressing the feasibility of collecting information on this population in the court system.

Mental disorders may take many forms and vary in severity. While some have a significant effect on court process, others may not be presented as an issue. In this paper, mentally disordered accused are defined as follows:

a) those deemed unfit to stand trial (UST);
b) those deemed not criminally responsible on account of mental disorder (NCRMD);
c) those who are diverted to treatment programs through community or provincial mechanisms instead of going to trial.

It should also be noted that there may be persons suffering from mental disorders who are not identified while moving through the courts systems and will need mental health treatment under a community or incarceratory sentence.

The mental health system has undergone significant reform over the past 25 years, moving toward de-institutionalised care coupled with medication to provide persons with mental illness greater freedom and the benefits of living in the community. Likewise, the justice system has moved away from the potential indeterminate detention associated with previous legislation, and new laws and policies to help mentally disordered accused return to suitable treatment programs and resume functioning in the community.

Interviews conducted with various professionals who work with mentally disordered accused suggest a common profile involving previous treatment for a mental disorder. These persons are generally not participating in a treatment program or have become resistant to medication at the time of the offence. Through law requiring a mentally disordered accused to be fit to stand trial, many accused are returned to a more functional level of mental health and treatment programs by the court system. Additional crossover occurs in providing care for mentally disordered persons in detention centres when alternative facilities are unavailable and in providing mental health care to inmates in correctional facilities who suffer from mental disorders but have been found responsible for their actions.

Methodology

Initial research involved a consultation with Department of Justice legal experts on the mental disorder provisions of the Criminal Code. A review of literature using both referrals from the Department of Justice and various health professionals was then conducted to help identify major trends and issues. An Internet search was also conducted to assist in researching details of the major trends and issues identified in early consultations.

In order to better understand the policies and practices of review boards[1], the chairperson and/or alternate chairperson of each respective board was asked to fill out a brief questionnaire (see Appendix E). Health professionals were also

[1] *Review boards are provincial/territorial bodies mandated by the* Criminal Code *to oversee the treatment of mentally disordered accused. The boards also make and review dispositions given to mentally disordered accused. For a more comprehensive description, please consult Section 3.*

interviewed in all provinces with hospital facilities for mentally disordered accused, with the exception of Newfoundland and Labrador (see Appendix D) and a summary of findings are presented in Section 4.

A separate review of literature was conducted to identify data collection practices abroad. Surveys in the United Kingdom and the United States of America that collect information on mentally disordered persons and the justice system are summarised in Appendices B and C, respectively.

2. Background

The treatment of mentally disordered persons in Canada

With the increasing availability of psychotropic medication and improvements in psychiatric diagnosis and care over the past three decades, mental health care facilities have progressively shifted the treatment of mentally ill persons from psychiatric facilities to a less restrictive environment within the community.

De-institutionalised treatment is regarded as both a patient preference and an effective treatment mechanism under ideal circumstances (Health Canada 1997). However, McEwan (2001) suggests there has been growing recognition over the past two decades that de-institutionalisation has not been coupled with an allocation of community resources to provide de-institutionalised persons with serious mental disorders adequate support. This lead to a project to identify best practices in mental health reform aimed at improving the state of mental health care and initiated by Health Canada.

The "Review of best practices in mental health reform" summarises the most effective elements of mental health programs across the country. Among the "best practices" highlighted are the effects of de-institutionalisation. The report notes that de-institutionalisation has spurred a movement toward a variety of housing types that, in ideal circumstances, re-integrate a patient at progressively more independent levels. The report also suggests that the treatment of choice among patients is a combination of community supports alongside a variety of treatment options. Further, community and residential programs can be substituted for extensive in-patient care.

The report addresses the homeless population and recognises that a significant number among that population are mentally ill. Other problems addressed in exploring the housing issue include a shortfall of appropriate housing for this population in many communities as well as a lack of funding resources for mental health services. The document concludes that the most effective course of treatment put forward in the document includes flexible and individualised supports, generic housing dispersed widely in the community and no restrictions on how long a client might remain in supportive housing.

Evolution of the mental disorder provisions of the Criminal Code

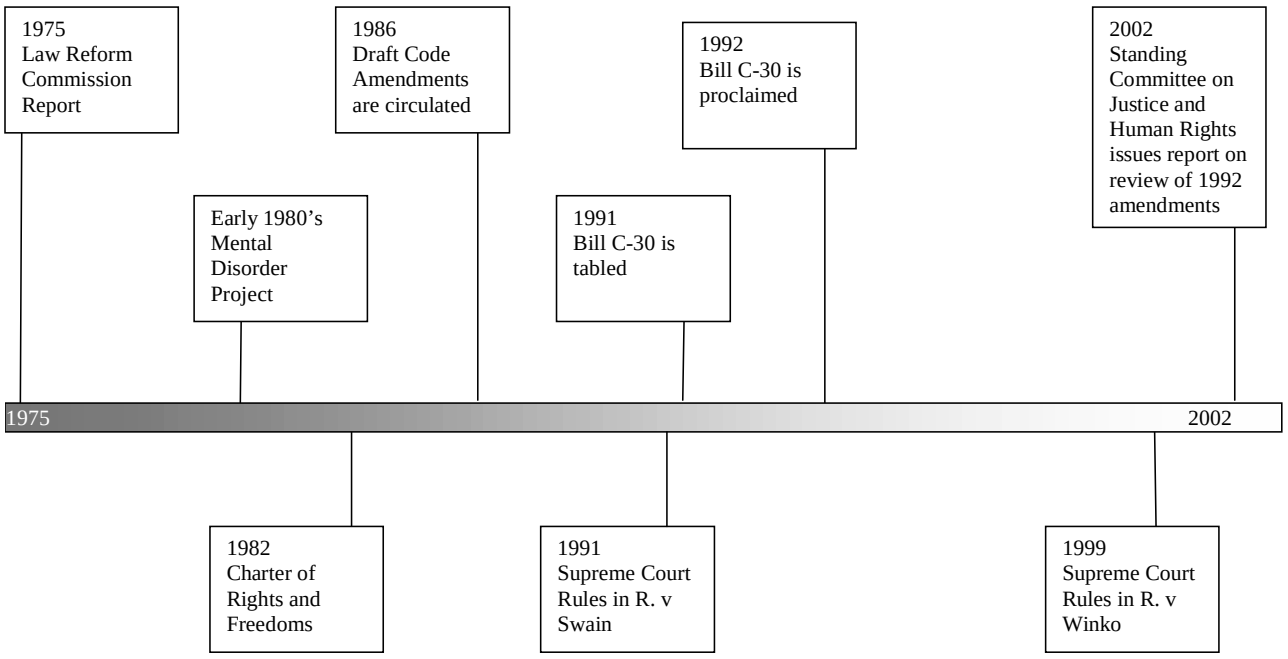
Similar to mental health practices, the treatment and rehabilitation of persons with mental disorders who come into contact with the justice system has evolved over the past two to three decades and moved away from universal and indeterminate detention in mental health facilities or psychiatric institutions. For a general overview of milestones, please consult Figure 2.1 Highlights of federal law and policy developments since 1975.

The provisions of the Criminal Code that relate to Mentally Disordered Accused changed significantly in 1992 with the proclamation of Bill C-30. Before that time, law and policy regarding persons found not guilty by reason of insanity was not codified and detention was at the pleasure of the Lieutenant Governor.

In the mid-seventies, the Law Reform Commission of Canada reviewed law and policy on mentally disordered persons. The report issued on the review, "Mental Disorder in the Criminal Process," summarised forty-four recommendations on current law and policy. They included the appropriate detention and treatment of mentally disordered accused with the safety of society and the rights of the accused in mind.

At the time the review was published, persons found not guilty by reason of insanity were held at the pleasure of the Lieutenant Governor for an unspecified period of time. In some cases, it was possible for a person who had been found not guilty by reason of insanity to be detained for a longer period of time than a person found guilty would be (Law Reform Commission of Canada, 1976). The report also expresses a preliminary concern that many of the problems in the

Figure 2.1
Highlights of federal law and policy developments since 1975



criminal process were created by "an unjustifiable fear of mentally unbalanced delinquents" that resulted in "needlessly long terms of detention" of mentally disordered accused.

In response to the report, the Department of Justice initiated the Mental Disorder Project in the early eighties. By 1985, the project had issued a report suggesting that the mental disorder provisions of the Criminal Code were in conflict with the Charter of Rights and Freedoms. Draft Code amendments were circulated in 1986 (Pilon 2001).

The Supreme Court of Canada ruling in R v Swain precipitated the amendments in 1991. The ruling declared that the automatic detention of persons found not guilty by reason of insanity without any hearing to determine the level of dangerousness or the appropriate disposition was, in fact in conflict with the Charter. The government six months to pass remedial legislation. The court also stated that the crown could not raise the issue of the defendant's mental capacity before the crown proved that the crime had been committed or where the accused has put their mental capacity into issue. The accused, however, has the right to raise the issue at any point during the trial.

In 1992, Bill C-30 was proclaimed, ended the former Lieutenant Governor's Warrant system and created the review boards[2] as they currently exist. The amendment also changed the former verdict of *not guilty by reason of insanity* to *not criminally responsible on account of mental disorder* (NCRMD). Review boards were also mandated to review each case involving unfit to stand trial (UST) and NCRMD accused on an annual basis.

In 1999, the Supreme Court of Canada ruled in R. versus Winko that detention is only warranted if the accused presents a significant threat to the public that is criminal in nature. In cases where evidence is not sufficient to establish a significant threat to the safety of the public, an absolute discharge must be issued.

[2] *Review Boards are legal bodies mandated to oversee the care and disposition of persons found unfit to stand trial and not criminally responsible on account of mental disorder.*

In 2002, the Standing Committee on Justice and Human Rights conducted the statuatorily required review of the mental disorder provisions of the Criminal Code and the implementation of new legislation. In addressing issues that have emerged since the changes, the committee also reviewed amendments that are not yet proclaimed. The report concludes with a recommendation for a second review in 2007 to allow for more systematic data collection.

Crossover between the mental health systems and the criminal justice system

The Mental Health system and the Criminal Justice system crossover when a mentally disordered accused is assessed and/or treated. Assessments can be conducted in jails, remand centres and mental health facilities and treatment is administered through the health system. A mentally disordered accused may remain in-hospital for treatment or may be sent to a program involving outpatient services or social workers. In some circumstances assessments are performed in detention centres and in health care facilities outside of the province or territory.

Many persons found unfit to stand trial and/or NCRMD have histories of psychiatric treatment for a mental disorder. The inter-play between the health and justice systems has resulted in some concern over the criminalization of mentally disordered persons as a means to provide them with treatment[3]. There have been cases identified where a patient has proven to be either resistant to treatment or has refused treatment and later become a threat to public safety. Provincial mental health legislation does not generally allow for institutionalisation and treatment of persons who refuse treatment unless that individual becomes a threat to either themself or the general public (Joncas 2002).

In many cases involving a finding of unfit to stand trial (please consult Section 3 for a detailed explanation of court processes), the accused arrives at court in need of treatment. Once the accused has been sent to hospital, he or she returns to court and if fit, is tried. The accused may later be found guilty, acquitted or if evidence of a mental disorder exists, to be not criminally responsible for his or her actions as a result of a mental disorder affecting him or her at the time of the offence.

In assessing and treating mentally disordered accused, the justice system calls on provincial and territorial mental health systems. Placing demands on the resources of respective hospitals and other psychiatric facilities may in fact have a negative impact on the overall quality of mental health care for forensic and non-forensic patients alike[4]. According to Nuffield (1997), detaining mentally disordered accused also presents unique problems to detention centres, in that additional security and resources are required to provide the accused with adequate mental health care and restraint, should the need arise.

The results of interviews with health professionals suggest there are often clinical histories of psychological or psychiatric treatment among individuals found unfit and not criminally responsible on account of a mental disorder. Similarities relating to personal histories may also exist.

Characteristics that may be shared by mentally disordered accused that were identified through qualitative research include:

- Severe mental illness resulting in previous hospitalisations;
- A tendency to be treatment resistant or else non-compliant with a medical regime;
- Fetal Alcohol Syndrome/Fetal Alcohol Effects (FAS/FAE) or other form of brain damage;
- Alcohol and drug abuse;
- Intoxication at time of offence;
- Similar diagnosis, including schizophrenia, psychoses, paranoia and others;

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[3] *Apart from being identified as a concern through qualitative interviews – a number of professionals raised the issue when asked "Is there anything you would like to add?" at the end of their questionnaire, this phenomena is also noted in MacGregor (1999) which looks at youth who are treated at the Maples Adolescent Treatment Centre. Health Canada's Best Practices also addresses the need for adequate housing facilities for persons with mental disorders in order to prevent vagrancy.*

[4] *In reviewing the mental disorder provisions of the Criminal Code, the Parliamentary Standing Committee on Justice and Human Rights issued a report that included a review of the Criminal Code's Hospital Orders for those offenders who are found to be criminally responsible for their actions but still in need of psychiatric treatment. The report stated "We are also persuaded that hospitals and other components of the mental health system are currently strained to the limits of their capacity. Therefore, the committee has concluded it would be irresponsible to recommend the implementation of provisions that would place greater burdens on institutions that are the legal and fiscal responsibility of another level of government."*

- Similar childhood experiences, including being from broken homes, abandoned as children or placed in several foster situations and
- A parent or parents who have substance addictions.

Cases involving FAS/FAE or other permanent brain damage are problematic as there may be no way to make these persons fit to stand trial. As these conditions are permanent, there is a possibility that they will remain in the health and justice systems indeterminately, however they are subject to an internal review of their condition which determines their fitness to stand trial.

There are also traits unique to mentally disordered youth who come into contact with the justice system. In addition to the support an adult may need, a youth must also reconnect with social supports in order to follow healthy psychological development. For example, the accused has special developmental needs pertaining to his or her education and/or peer group (MacGregor 1999). A nurturing family environment is essential in a youth's rehabilitation.

Special programs for mentally disordered accused

A wide variety of facilities (including general hospitals, psychiatric institutions, and supported housing) house mentally disordered accused who receive hospital orders and/or treatment. While some provinces are moving toward a centralised mental health system for this group, others operate on a more dispersed principle to better accommodate geographical challenges and the needs of the accused.

Facilities and facility types vary across the country. Provinces and territories have all tailored facilities and programs to accommodate the unique needs of their respective populations. Larger jurisdictions may require a number of different facilities to accommodate all patients. Treatment programs in all provinces and territories involve a general re-integration of the accused into the community through a variety of facilities and health care professionals.

Community Treatment Orders

Community Treatment Orders (CTO) allow some provincial mental health systems to provide the benefits of de-institutionalised treatment to a seriously mentally ill person. Orders allow the patient to enjoy the freedom of living within the community and to consent in advance to any treatment or detention that might be necessary should their condition deteriorate. A mentally disordered person's return to treatment through a CTO may take several forms. Often, it is invoked when a member of the community recognises that the patient is in need of further mental health treatment. While re-entry generally involves doctors, family members and general social contacts, in some cases the patient may come into contact with the police and be returned to their treatment program immediately.

Court Diversion

In some provinces, mentally disordered persons charged with minor offences may be sent directly to a treatment program rather than go through full court procedures. Diversion also serves to provide the correctional system with relief from treatment, safety and control issues mentally disordered persons may present while incarcerated (Nuffield, 1997). Diversion may occur upon contact with police, initial incarceration or upon arrival in court. In Ontario, for example, the accused may be referred to a caseworker at an initial hearing in provincial court. Diversion is generally only available to those accused who are willing to participate in a treatment program, or who are covered by a community treatment order in those provinces where they are available.

3. Key processes involving mentally disordered accused in the adult criminal court system

Current court processes involving mentally disordered accused can be lengthy and complex. In some circumstances, a case will be adjourned to permit assessment and treatment. For example, an accused may have stopped taking medication prescribed by a psychiatrist for a mental disorder before committing an offence. When brought to trial, the accused is found unfit and sent for treatment. Once the accused's condition is stabilised, court proceedings continue and may conclude with a finding of NCRMD as a result of the accused being off his or her medication at the time of the offence. In other circumstances, the accused may not be found fit to stand trial initially, but later found fit, tried and convicted.

Unfit to stand trial

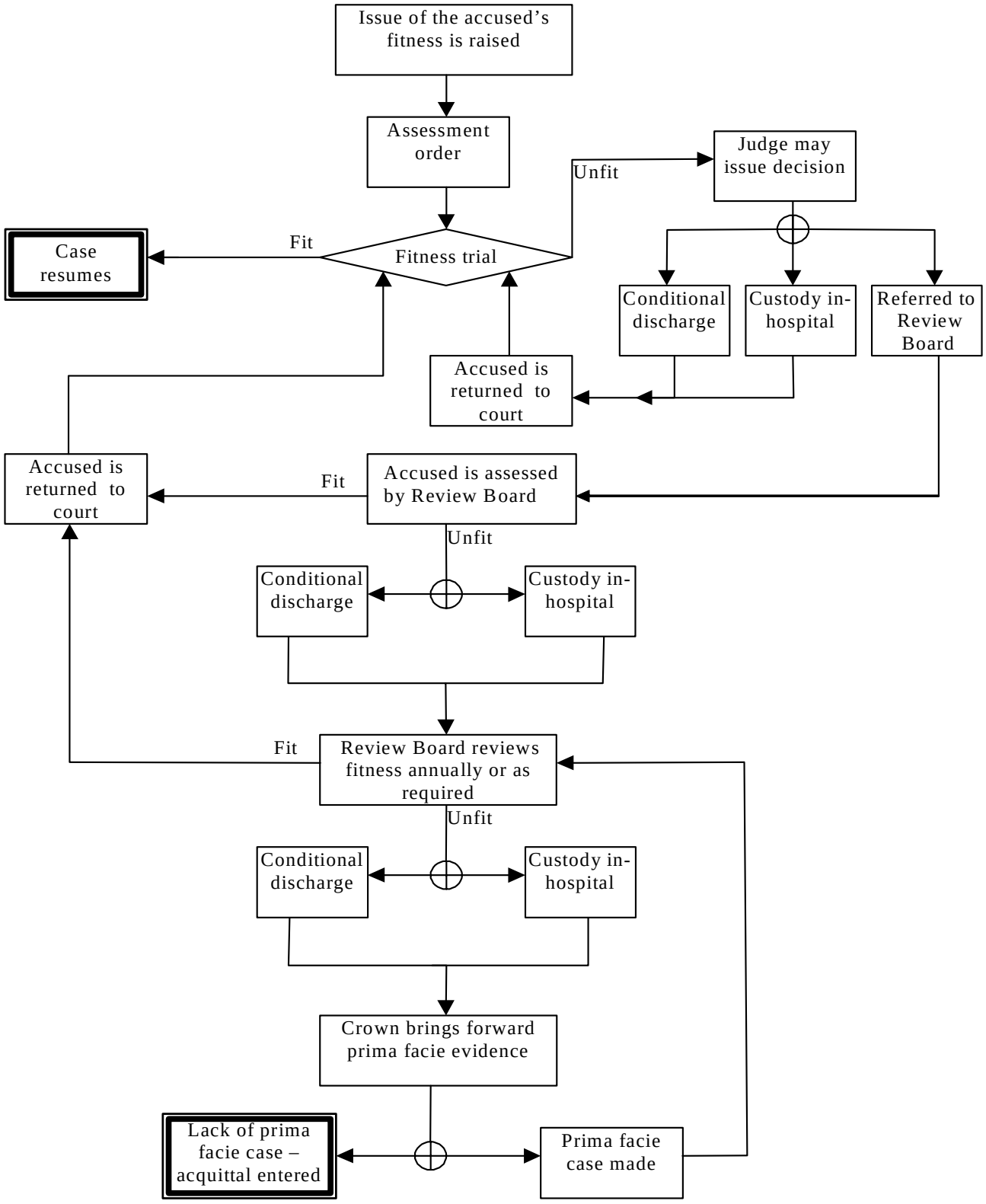
An accused may be found unfit to stand trial (UST) when it is recognised that he or she is not fully capable of instructing counsel or is not capable of understanding the nature and consequences of a trial. The processes surrounding an accused who has been found UST can be complex, as they involve both the judicial and health systems (see Figure 3.1 Key processes in assessing an accused's fitness to stand trial).

Where the accused is found UST, there are two possible scenarios: in the first, the judge issues a disposition for either detention in hospital or conditional discharge and the accused is assessed for fitness within 45 days. In some cases, the accused may be returned to court as soon as they become fit. If the accused remains unfit after 90 days, the accused appears before a Review Board for assessment and disposition.

If the accused is still UST after the initial 90 days, the case is reviewed on an annual basis by the Review Board. In these circumstances, the prosecutor is required to prove that there is enough evidence to bring the case to trial *(referred to as prima facie*) every two years and at any time the accused requests the proceeding. In cases where the court determines that there is no longer sufficient evidence to prosecute the accused, the case is dropped and an acquittal is entered.

When the accused is found to be fit, the trial may resume. The accused may be found UST again at any point before the verdict is reached. However, if the accused was detained in custody at the time he or she was deemed fit and there is reason to believe that he or she would become UST if released, the court may require the accused to remain in-hospital for the duration of the trial. At the time this report was written, it was possible for an accused to remain unfit and the case open indefinitely, provided the prosecution could maintain *a prima facie* case. This can be a major difficulty in cases involving permanently unfit persons.

Figure 3.1
Key processes in assessing an accused's fitness to stand trial



Not criminally responsible on account of a mental disorder

The accused's mental state at the time the offence was committed determines whether an NCRMD verdict will result. According to the Criminal Code, the accused had to have been suffering from a "disease of the mind" that prevented the accused from understanding the consequences of his or her actions or of knowing they were wrong. NCRMD is established through an assessment ordered by the court once the accused has raised the issue of a mental disorder at the time the offence was committed. The prosecutor may only raise the issue after it has been established that the accused did, in fact commit the act in question or after the accused has put his mental capacity into issue. The general processes surrounding a finding of NCRMD are shown in Figure 3.2 Key processes in determining criminal responsibility in cases involving mentally disordered accused.

A verdict of NCRMD is not synonymous with a finding of guilt. Rather, the verdict means that the court has ruled that the accused was not criminally responsible for his or her actions at the time the offence was committed. As a result, in cases where more severe sentences are awarded for repeat offences, the offence cannot be considered a previous conviction.

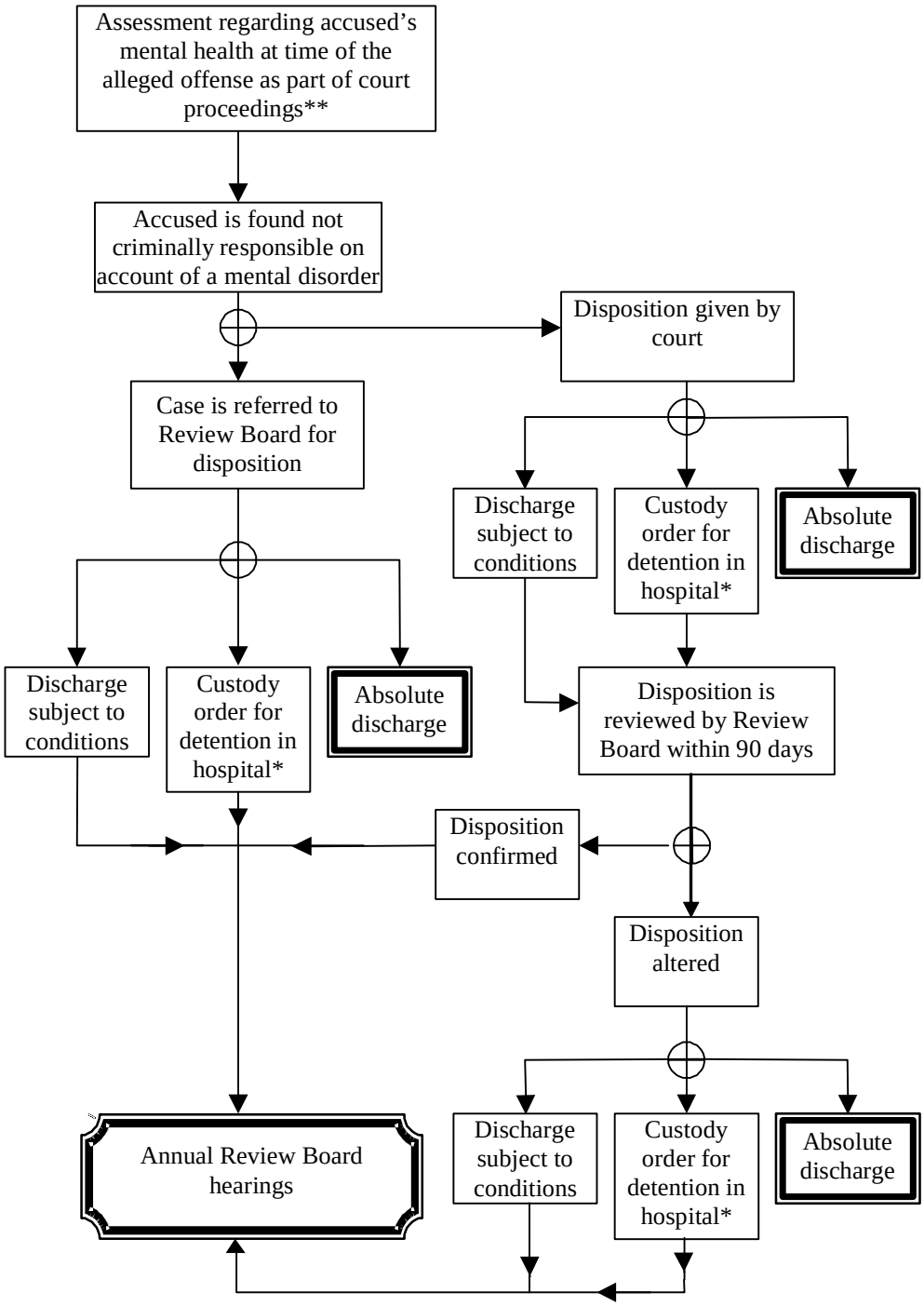
Although the court may either give a disposition or defer the action to a Review Board, if either the prosecutor or the accused apply for the court to give the disposition itself, and if able to do so, the court must comply. The court may give the following dispositions:

- Detention in-hospital
- Conditional discharge
- Absolute discharge

When no application is made for the court to give a disposition and no disposition is made, the provincial or territorial Review Board does so within 45 days of the verdict. Dispositions given by the court are also reviewed by the Review Boards within 90 days and may be altered at that juncture. The only disposition a court may give that does not later arrive at a Review Board hearing is that of an Absolute Discharge.

Those accused who receive dispositions for detention in-hospital are not required to submit to treatment while in-hospital – the disposition is meant to detain the accused in an environment where appropriate medical and psychiatric care is available to them. In cases where the accused refuses treatment that may be necessary to maintain good mental health, however, the accused's state of health may deteriorate to a point where treatment is necessary. In these cases, treatment is administered in accordance with respective provincial/territorial mental health policy.

Figure 3.2
Key processes in determining criminal responsibility in cases involving mentally disordered accused



* While both the court and Review Board have the authority to detain a person found NCRMD in hospital, the accused may refuse treatment while detained.

** In accordance with the decision of the Supreme Court of Canada in R. v. Swain in 1991, the crown may not raise the issue of the accused's mental state before the crown proved that the crime had been committed or where the accused had put their mental capacity into issue.

Review boards

Cases involving an accused found NCRMD arrive at the review board at one of two intervals: the first is after the court has given a disposition and the second is after a court has deferred giving the disposition to the board. In the first instance, the review board reviews the court's disposition and may alter the conditions[5]. In the second, the board reviews the case, issues and original disposition. In either instance, the review board reviews the accused's disposition every year.

Review boards base their decisions on a significant amount of information, such as the nature of the case, conclusions of assessments and information supplied by the court and hospitals. While the information supplied varies on a case by case basis, that which may be used in the decision includes:

- Charge information
- Transcript of trial proceedings
- Victim impact statement
- Criminal history
- Risk assessment
- Clinical history (can include previous admissions to hospital)
- Diagnosis (can include previous diagnosis and "most responsible diagnosis"[6])
- Results of psychological tests
- Results of neurological tests
- Results of laboratory tests
- Social assessment
- Family history
- Hospital's recommendation

The information submitted to the board can come from a variety of sources, including the court system, hospitals and witnesses the board may call.

Composition of review boards

The *Criminal Code* mandates the lieutenant governor in council of a province or territory to appoint a minimum of five members to a Review Board. These members include a chairperson who is qualified to be a judge[7] as well as at least one member who is qualified to practice psychiatry in the province. In cases where there is only one psychiatrist on the board, another must be either a physician or psychologist who has had experience and training in the mental health field. Boards also have at least one alternate chair to act in the absence of the Chair or else assist with a heavy caseload. Conversely, jurisdictions that meet only occasionally over the course of the year have only one alternate chair (Table 3.1).

Boards take various measures to execute the Criminal Code. While many provinces have adequate resources and personnel to staff Review Boards, others rely on professional members of their boards where necessary . Board size also varies in order to accommodate workload and availability of current board members. In some circumstances, the accused is sent out of province for treatment or assessment as a result of local resource shortfalls. Lay-person members of Review Boards are almost always from within the province or territory.

The number of review board members also varies from jurisdiction to jurisdiction, depending on caseload, and geographic necessity. Caseload data for the years 2000 and 2001 supplied by a Justice Canada study can be viewed in Appendix A. Specific jurisdictional information on review board size is presented in Table 3.1 Review board composition by province.

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[5] *When the court gives a disposition of Absolute Discharge, the case never goes before a Review Board.*

[6] *Most responsible diagnosis refers to the mental disorder most likely to be affecting a patient, based on the results of psychological and/or psychiatric testing.*

[7] *Under section 672.4 (1) of the Criminal Code, the chairperson of the Review Board can be currently appointed as a judge, retired from such a post or qualified for the post.*

Table 3.1
Review Board composition by province

	Review board size	Number of alternate chairs	Members from other provinces
Newfoundland and Labrador	5	1	
Prince Edward Island	6	1	Nova Scotia
Nova Scotia	6	1	
New Brunswick	6	1	
Quebec	32	10	
Ontario	135	31	
Manitoba	8	3	
Saskatchewan	5	0	
Alberta	11	2	
British Columbia	18	4	
Yukon	5	1	Alberta and British Columbia
Northwest Territories	..	..	
Nunavut	21	10	Alberta and Ontario

Source: *Questionnaire for Review Board Chairs, Appendix E*
Note: *The Ontario Review Board has a high number of part time and occasional members who contribute to board activities*

A note on young offenders[8]

Assessments for fitness to stand trial and criminal responsibility of young persons with mental disorders are quite similar to those involving adult offenders. However, in cases involving a youth who is UST, the prosecution has to demonstrate the prima facie case once a year rather than every two years. In all cases, review boards are required to take into consideration any submission made by the accused's parents as well as any special needs the young person might have. Young offenders deemed UST and NCRMD who are sent for treatment may only be held in hospitals designated by the Minister of Health as appropriate for the treatment and assessment of youth.

[8] *The Youth Criminal Justice Act, which was proclaimed but not yet in effect at the time this report was written, was not expected to alter the policy outlined here.*

4. Questionnaire results

The following are the results of the questionnaire for health experts (presented in Appendix D). Where responses varied significantly, a list has been presented with the number of respondents providing the answer shown in parentheses after each item (x of 10). The questionnaire was administered to all provinces housing psychiatric facilities that offer care to mentally disordered accused, with the exception of Newfoundland and Labrador. The Northwest Territories and Nunavut were not included as neither jurisdiction had appropriate facilities at the time this report was written.

Question 1

What is your involvement with mentally disordered persons who come into contact with the justice system?

Table 4.1
Occupations of respondents to questionnaire

Respondent involvement with mentally disordered accused	Total number of respondents
Head of Psychiatric facility	5
Review board psychiatrist/psychologist	2
Other professional position in a psychiatric facility	3

- Other professional position in psychiatric facility involves clinical chief, vice president, and other executive positions involving psychiatric facilities and clinics.

Question 2

To your knowledge, are there any formalized tests administered in your province to determine whether an accused is either unfit to stand trial or not criminally responsible on account of mental disorder?

- All respondents answered no to this question, however, 3 respondents indicated that guidelines set out in the Criminal Code for determining fitness to stand trial are followed. Two other respondents provided details on tests that are sometimes administered to assist in determining fitness to stand trial and criminal responsibility.

Question 3

In your personal experience, what sort of clinical history is presented to a review board by the hospital (or institution)?

- Criminal history (10 of 10)
- Clinical history (can include previous admissions to hospital) (10 of 10)
- Diagnosis (can include previous diagnosis and “most responsible” diagnosis) (8 of 10)
- Social assessment (5 of 10)
- Results of neurological tests (1 of 10)
- Results of laboratory tests (1 of 10)
- Risk assessment (2 of 10)
- Results of psychological tests (2 of 10)
- Hospital’s recommendation (2 of 10)
- Personal history (2 of 10)
- Medical history (2 of 10)
- Family history (1 of 10)
- Behavioural history (1 of 10)

Question 4

In your personal experience, is there generally a history of psychological or psychiatric treatment among individuals found unfit and not criminally responsible on account of a mental disorder?

- All respondents indicated yes to this question.

Question 4b

If yes, in your personal experience, have you found that there are similarities relating to those clinical histories among individuals who are found unfit to stand trial or not criminally responsible on account of a mental disorder?

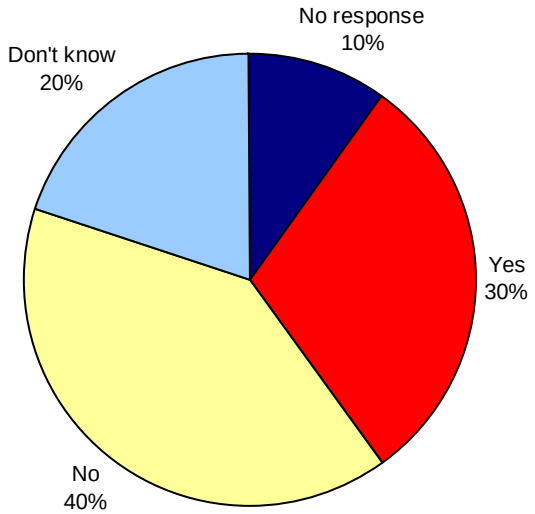
- A tendency to be treatment resistant or else non-compliant with a medical regime (4 of 10)
- Alcohol and drug abuse (3 of 10)
- Similar diagnosis, including schizophrenia, psychoses, paranoia and others (3 of 10)
- Severe mental illness resulting in previous hospitalisations (2 of 10)
- Intoxication at time of offence (1 of 10)
- Fetal Alcohol Syndrome, Fetal Alcohol Effects (FAS/FAE) or other form of brain (damage) (1 of 10)
- Similar childhood experiences, including being from broken homes, abandoned as children or placed in several foster situations (1 of 10)
- A parent or parents who have substance addictions (1 of 10)
- Not enough experience to answer (1 of 10)

Question 5

In your personal experience, have you found that there are always enough beds or enough space for all persons found unfit to stand trial or not criminally responsible on account of a mental disorder?

- 4 Respondents indicated no, 3 indicated yes, 2 respondents indicated “don’t know” and one did not answer.
- PEI is without forensic facilities.
- The ten provinces have psychiatric facilities within their jurisdictions. Nunavut, the Northwest Territories and the Yukon did not have psychiatric facilities that provide mentally disordered accused with 24-hour care at the time this report was written.

Figure 4.1
Space available for persons found UST and NCRMD



Question 5b

If no, where are these individuals sent when there is not enough space?

- Other hospitals within the province (3 of 4)
- Prison (3 of 4)
- Other clinics within the hospital (2 of 4)
- Detention centres (2 of 4)
- Remand centres (1 of 4)
- Psychiatric institutions in other provinces (1 of 4)
- No answer (1 of 4)

Question 6

To your knowledge, is provincial legislation or policy in your province expected to change in the near future?

- Although all respondents but one indicated that there is no change in provincial legislation in the near future, two indicated that processes involving accused youth will change under the Youth Criminal Justice Act. One respondent indicated "Don't know."

Question 7

Is there any information that you believe would be valuable to either your own board or to policy makers/experts in your field relating to mentally disordered persons who come into contact with the justice system?

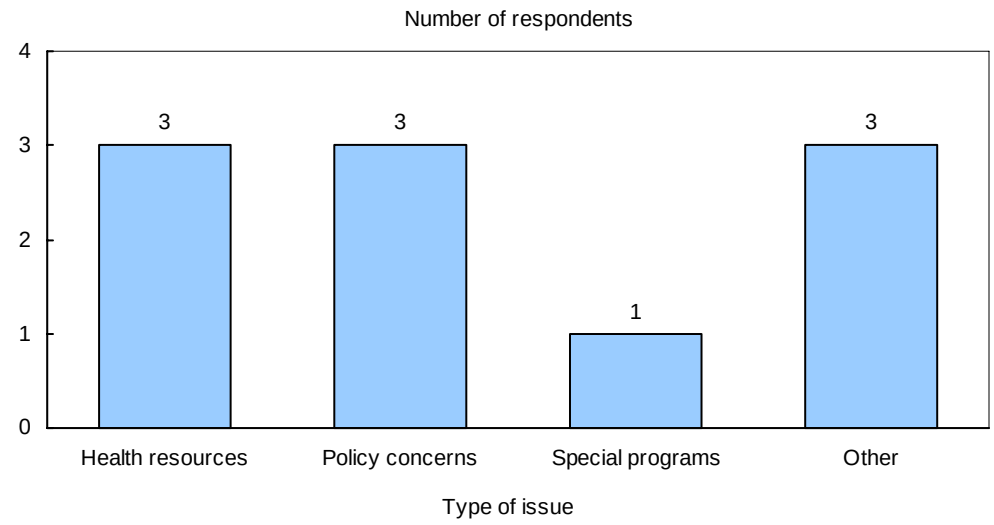
- General information about the special needs of mentally disordered accused (2 of 10)
- Sharing review board statistics (2 of 10)
- The number of mentally disordered accused in the system (1 of 10)
- Proportion of patients from the forensic system versus proportion of patients from the health system (1 of 10)
- How review boards set parameters for patients (1 of 10)
- Capacity limitations of each region (1 of 10)
- General information about local provincial programs and procedures, i.e. the child welfare system (1 of 10)
- General information on review board proceedings, i.e. what information is relayed between the hospital and the board (1 of 10)
- Information on review boards suitable for parents and families (1 of 10)

Two respondents indicated "no" and two did not respond to this question.

Question 8

Are there any particular issues you would like to raise or anything you would like to add?

Figure 4.2
Types of issues raised by health professionals



Notes:

- The above responses will not add up to the total number of respondents as some provided comments in more than one area.
- Health resources includes concerns expressed relating to resources available the health sector.
- Policy concerns includes concerns expressed relating to the use of the Criminal Code to treat persons who would otherwise not receive treatment under provincial and territorial mental health legislation.
- Special programs includes the mention of special initiatives taken by a jurisdiction to treat mentally disordered accused.
- Other includes suggestions for information that should be available to families of mentally disordered accused as well as notes regarding answers to other questions.
- Four respondents answered this question “no” and another three left this question blank.

5. Data collection possibilities for automated court information systems

Current policy and court administrative practices may allow for the collection of a variety of variables relating to mentally disordered accused. Basic counts of hearings and outcomes could provide valuable insight on the extent current law and policy is implemented by the courts. Moreover, information that could be derived from administrative data would provide insight into the amount of time cases involving mentally disordered accused remain active. The feasibility of collecting the variables that follow is to be examined in a separate study.

Number of persons who have a fitness hearing

The number of fitness hearings may reflect the number of accused who are suspected of having a mental disorder that is interfering with their ability to understand court room activities at the time of trial.

Number of persons found unfit to stand trial

This data would provide an indication of how many accused are not fit to stand trial versus the number of accused who have a fitness hearing[9].

Treatment orders and conditional discharges of persons found unfit to stand trial

This information would be demonstrative of both the severity of the accused's mental disorder as well as the mental health resources the court system requires. Court data would have some limitations in this area as all dispositions given by the court, with the exception of absolute discharges, are reviewed – and potentially modified - by a review board within 45 days.

Number of persons found NCRMD

This data would provide an indication of how many persons are found not criminally responsible in a given year.

Dispositions for persons found NCRMD

This information may indicate the severity of the accused's mental illness and the health resource needs of the court system[10]. Court data would have some limitations in this area as all dispositions given by the court, with the exception of absolute discharges, are reviewed by a review board within 45 days.

Derived variable

Time frames for assessment and treatment of persons found unfit to stand trial

Using the dates for the conclusion of a fitness hearing and the resumption of court proceedings, it may be possible to derive the amount of time an accused waits to be returned to court. Time frame information may provide indication of how long an accused waits for assessment or the amount of time an accused waits to return to court after being assessed.

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[9] *Numbers derived from the courts system would be higher that those of the Review Boards as persons found unfit to stand trial may become fit and return to trial before the case is sent to a Review Board.*

[10] *Although dispositions are initially made in court unless the judge defers to a Review Board, the accused will have his or her case reviewed by the board at a later time unless the disposition given was an absolute discharge. In these cases, a Review Board never reviews the accused. Dispositions would best be measured using data that tracks the number of cases found NCRMD in court as well as the number of absolute discharges given to these cases at that juncture.*

6. International information on mentally disordered persons in the justice system

International data collection practices relating to mentally disordered persons in the justice system were examined as part of preliminary research for this report. While no data were located relating to court procedures that might be comparable to those of Canada, data addressing other components of the criminal justice system were identified (for example, correctional facilities in the US). The following is a brief overview of information available in the US and UK.

The Bureau of Justice Statistics in the US draws its data on the mental health of convicted persons from a variety of sources. The "Special Report on Mental Health and Treatment of Inmates and Probationers," for example, draws on the 1997 Surveys of Inmates in State and Federal Correction Facilities, the 1995 Survey of Adults on Probation and the 1996 Survey of Inmates in Local Jails. Although none of these surveys deal exclusively with mentally disordered offenders, each includes fields that address mental disorders.

In 2000, for example, the Bureau conducted a Census of State and Federal Adult Correctional Facilities that included a survey involving institutional policies and facilities and resources made available to inmates on-site. Meanwhile, the 1996 Survey of Inmates and Local Jails allowed inmates to self identify as having a "mental or emotional condition," and whether they had made use of a variety of mental health services. Variables considered by the US Census of State and Federal Adult Correctional Facilities and an overview of some of the data presented can be viewed in Appendix B.

Information presented by the United Kingdom Home Office relating to Mentally Disordered Offenders provides more detailed profile information as well as data on which mental health facilities "restricted patients" are detained in. Collected through the Home Office computer system, data is reflective of the number of offenders detained in-hospital as restricted patients under respective legislation. Similar to Canada, not all hospitals where mentally disordered offenders are housed are high security or meant to exclusively detain and treat restricted patients. In some circumstances, psychiatric hospitals house both restricted and other patients. The Home Office Series Statistical Bulletin on mentally disordered offenders reports on hospital information relating to persons detained through a restriction order. Variables and selected data relating to mentally disordered offenders in the UK are presented in Appendix C.

7. Summary and note on data limitation

Recently implemented policies and procedures in managing cases involving mentally disordered persons have created the opportunity to investigate data collection. Although processes surrounding these individuals can be complex, the court system may provide a juncture at which the use and affects of these new policies can be measured. A feasibility study following this report will be conducted. However, court information should be approached and analysed with a cautionary note: dispositions awarded to mentally disordered accused found UST and/or NCRMD are subject to change when brought before a review board. Also, programs such as court diversion and community treatment orders as well as other initiatives in both the health and justice sectors provide additional treatment mechanisms for mentally disordered accused that would not necessarily be available in court data.

References

Beck, Allen J. and Laura M Maruschak (2001). *Mental Health Treatment in State Prisons, 2000. Bureau of Justice Statistics Special Report*. US Department of Justice, Office of Justice Programs

(2002) *Criminal Code of Canada*

(1989*) Criminal Code. of Canada*

Ditton, Paula M. (1999). *Mental Health and Treatment of Inmates and Probationers. Bureau of Justice Statistics Special Report*. US Department of Justice, Office of Justice Programs

Johnson, Steven and Ricky Taylor (2001*). Statistics on Mentally Disordered Offenders 2000*. Home Office Statistical Bulletin

Johnson, Steven and Ricky Taylor (2000*). Statistics on Mentally Disordered Offenders 1999*. Home Office Statistical Bulletin

Johnson, Steven and Ricky Taylor (2000). *Statistics on Mentally Disordered Offenders in England and Wales 1998*. Home Office Statistical Bulletin

Joncas, Lucie (2002). *The Canadian Criminal Code and Provincial Mental Health Acts: Related Statutes?* National Judicial Institute Criminal Law Seminar

Kane, Catherine (2001). *Information Note: Part XX.1 of the Criminal Code*. Department of Justice, Ottawa

MacGregor, Bill and James Quan (1999). *A Review of Unfit and NCRMD Cases Detained at the Maples Adolescent Treatment Centre*. June 1999

Marceau, Joanne (2001). *Procedure for Mental Disorder in the Criminal Code*. Ottawa: Public Prosecutions Branch

McEwan, Kimberly (2001). *Performance Monitoring Tools*: Health Canada

(1976) *Mental Disorder in the Criminal Process*. Law Reform Commission of Canada. Ottawa

(2002*) Mentally Disordered Accused and the Justice System in British Columbia*. British Columbia. British Columbia: Ministry of Attorney General, Criminal Justice Branch

Nuffield, Joan (1997). *Diversion Programs for Adults*. Solicitor General of Canada

Pilon, Marilyn (2001). Review of the Mental Disorder Provisions of the *Criminal Code*, Ottawa: Parliamentary Research Branch: Law and Government Division

(1997) *Review of Best Practices in Mental Health Reform*. Health Canada

(2002) *Review of Part XX.1 of the Criminal Code. Report of the Standing Committee on Justice and Human Rights*. Ottawa

(2001) *Rights and Responsibilities: Mental Health and the Law*. The Ministry of Health and Long-Term Care: Ontario

Schneider, Richard D., Maureen Forestell and Sharon MacGarvie (2002). *Statistical Survey of Provincial and Territorial Review Boards (Part XX.1 or the Criminal Code of Canada).* Department of Justice Canada

(2002) *The Role Recovery Practitioner Handbook*: *East Coast Forensic Hospital*, Nova Scotia: East Coast Forensic Hospital

(2002) Young Offenders Act. Ottawa: Queen's Printer

Appendix A - Review Board caseload statistics

Table A.1
Review Board caseloads by province 2000/01

Jurisdiction	New unfit		New NCRMD		Total active cases	
	2000	2001	2000	2001	2000	2001
Newfoundland and Labrador	4	3	7	3	**26**	**28**
Prince Edward Island	0	0	0	0	**4**	**3**
Nova Scotia	2	2	22	36	**83**	**98**
New Brunswick	3	11	11	24	**62**	**78**
Quebec	40	41	319	362	**912**	**906**
Ontario	91	66	126	132	**952**	**966**
Manitoba	3	..	8	..	**70**	**75**
Saskatchewan	1	4	2	2	**30**	**34**
Alberta	13	11	17	20	**111**	**113**
British Columbia	11	..	72	..	**411**	**411**
Yukon	2	1	0	2	**2**	**3**
Northwest Territories	0	0	0	0	**0**	**0**
Nunavut	1	0	1	0	**2**	**2**
TOTAL	**171**	**139[p]**	**585**	**581[p]**	**2665**	**2717**

Source: *Justice Canada. Statistical Survey of Provincial and Territorial Review Boards, February 2002*
P= preliminary figure (subject to revision)

Notes:

- **Total active cases** includes unfit and NCRMD cases that were already under review board jurisdiction as well as the year's new cases.
- Cases involving a disposition of Absolute Discharge and cases involving a short-term unfit accused may not be referred to a review board. Numbers presented here for new unfit and new NCRMD may be slightly lower than actual new cases as determined in court.
- Statistics for British Columbia are based on fiscal years (April 1 to March 30). All other provincial data are based on calendar year.
- The Northwest Territories only processed one case between 1992 and 2001. The territory has reported that its caseload has increased for 2002.
- Numbers for New Unfit and New NCR in Manitoba and British Columbia were not available at the time of data collection.

Appendix B - U.S. data collection model

Table B.1
Mental health screening and treatment in state correctional facilities, by type of facility, June 30, 2000

Mental health policy	Type of facility		
	All facilities	Confinement facilities	Community-based facilities
Any screening/treatment	**1394**	**1047**	**347**
Screen inmates at intake	1055	855	200
Conduct psychiatric assessments	990	864	126
Provide 24-hour mental health care	776	693	83
Provide therapy/couseling	1073	926	147
Distribute psychotropic medications	1115	910	205
Help released inmates obtain services	1006	790	216
No screening/treatment	**125**	**50**	**75**
Not reported	**39**	**12**	**27**
TOTAL	**1558**	**1109**	**449**

Source: *U.S. Department of Justice Statistics, Census of State and Federal Adult Correctional Facilities*

Notes:

- The survey covers 84 Federal Facilities, 1320 State facilities and 264 private facilities in operation on June 30, 2000. This table excludes Federal facilities and 26 privately operated facilities where at least half of inmates were under federal authority.
- Included in this data are facilities where at least half of inmates are regularly permitted to depart unaccompanied and those facilities that primarily operate for community corrections, work release or pre-release.

Table B.2
Estimated number of mentally ill inmates and probationers

Indication of mental illness	Estimated number of offenders			
	State prison	Federal prison	Local jail	Probation
Identified as mentally ill	179,200	7,900	96,700	547,800
Reported a mental or emotional condition	111,300	5,200	62,100	472,000
Admitted overnight to a mental hospital	118,300	5,000	60,500	281,200

Source: *U.S. Department of Justice Statistics, midyear 1998 counts from the "National Prisoner Statistics and Annual Survey of Jails" and preliminary yearend counts from the "Annual Probation Survey."*

Notes:

- Inmates were asked to self identify as having a mental or emotional condition and probationers were asked to self identify as having been told by a mental health professional that they have had a mental or emotional disorder.
- All respondents were asked whether they had been admitted overnight to a mental hospital.

Variables collected by census of state and federal adult correctional facilities

Mental health policy
- Any?
- Screen inmates at intake?
- Conduct psychiatric assessment?
- Provide 24-hour care?
- Provide therapy or counceling?
- Distribute psychotropic medications?
- Assist releasees?

Inmate characteristics
- Number of inmates receiving 24-hour care
- Number of inmates in therapy or counselling
- Number of inmates receiving psychotropic medications

Facility characteristics
- Facility operation
- Private/public
- Confinement/community based
- Males only/females only/both
- Size
- Rated capacity
- Current capacity
- Security level

Special functions
- Reception/diagnostic centre
- Community corrections
- Medical treatment
- Mental health treatment
- Alcohol/drug treatment

- Boot camp/youthful offenders
- Other

Most serious offences
- Violent offences
- Property offences
- Drug offences
- Public order offences

Variables from annual survey of jails and the annual probation survey

Report a mental or emotional condition: because of a mental or emotional problem inmate had…
- Been admitted to hospital overnight
- Taken a prescription medication
- Received professional counselling or therapy
- Received other mental health services

Other variables
- Homelessness
- Employed in month before arrest
- Sources of income
- Criminal history
- Number of prior probation/incarceration sentences
- Family member ever incarcerated while growing up?
- Ever abused before admission?
- Alcohol/drug use
- History of alcohol dependence
- Characteristics of drinking habits
- Sex
- Age
- Race/Hispanic origin
- Number of fights since admission
- Charged with breaking prison or jail rules
- Maximum sentence length and time served by inmates

Victim characteristics
- Gender of victims
- Age of youngest victim
- Victim-offender relationship
  - Knew victim
  - Relative
  - Inmate
  - Friend/Acquaintance
  - Other
  - Knew none of victims
- Use of weapon

Appendix C - U.K. data collection model

Table C.1
Restricted Patients admitted to hospital by type of mental disorder

Type of mental disorder	1995	1996	1997	1998	1999	2000
Mental illness	898	954	975	987	986	840
Mental illness with other disorders	21	31	25	23	23	36
Psychopathic disorder	46	47	38	35	40	36
Mental impairment	18	18	24	16	33	28
Mental impairment with psychopathic disorder	4	6	4	2	3	3
Severe mental impairment		3	4			4
Not known	21	20	22	28	34	21
All mental disorders	1008	1079	1092	1091	1119	968

Source: *Home Office Statistics on Mentally Disordered Offenders 2000, Home Office Statistical Bulletin.*

Notes:

- Restricted patients are persons who are compulsorily admitted to hospital who may be awaiting trial, transferred to hospital from prison, convicted offenders with mental disorders or otherwise held for legal reasons. This category may also include persons held under the Immigration Act, but restrictions are not mandatory.

Information provided through the Home Office System

Type of hospital
- High security for males
- High security for females
- Other hospitals for males
- Other hospitals for females

Number of restricted patients

Legal category
- Hospital order with restriction order
- Transferred from prison service establishment after sentence
- Transferred from prison service establishment while unsentenced or untried
- All transferred from prison
- Recalled after conditional discharge
- Transferred from Scotland, Northern Ireland, etc.
- Unfit to plead
- Not guilty by reason of insanity

- Hospital and limitation direction
- All legal categories

Type of offence
- Violence against the person
- Sexual offences
- Burglary
- Robbery
- Theft and handling stolen goods
- Fraud and forgery
- Criminal damage
- Other indictable offences and summary offences
- All offences
- Civil prisoners and immigration detainees
- All patients

Type of mental disorder
- Mental illness
- Mental illness with other disorders
- Psychopathic disorder
- Mental impairment
- Mental impairment with psychopathic disorder
- Severe mental impairment
- Not known
- All mental disorders

Other variables
- Period in hospital
- Discharges and disposals of restricted patients
- Reconviction of restricted patients
- Admission of unrestricted patients
- Sex

Appendix D - Questions for health professionals

1. What is your involvement with mentally disordered persons who come into contact with the justice system

   Review Board psychiatrist
   Review Board psychologist
   Head of psychiatric institution
   Other (specify)

2. To your knowledge, are there any formalized tests administered in your province to determine whether an accused is either unfit to stand trial or not criminally responsible on account of a mental disorder?

   Yes/No

   2. a) If yes: What are these tests?
   2. b) For each test: When is it administered?
   2. c) For each test: Who requests and who administers it?

3. In your personal experience, what sort of clinical history is presented to a Review Board by the hospital (or institution)?

   For example:

   Criminal History
   Clinical History (if any)
   Diagnosis/Previous Diagnosis

4. In your personal experience, is there generally a history of psychological or psychiatric treatment among individuals found unfit and not criminally responsible on account of a mental disorder?

   Yes/No

   4. a) If yes: In your personal experience, have you found that there are similarities relating those clinical histories among individuals who are found unfit to stand trial or not criminally responsible on account of a mental disorder?

5. In your personal experience, have you found that there are always enough beds or enough space for all persons found unfit to stand trial or not criminally responsible and under a hospital order?

   5. a) If no: Where are these individuals sent when there is not enough space?

6. To your knowledge, is provincial legislation or policy in your province relating to this issue expected to change in the near future?

7. Is there any particular information/data that you believe would be valuable to either your own board or to policy makers/experts in your field relating to mentally disordered persons who come into contact with the justice system?

8. Are there any particular issues you would like to raise or anything you would like to add?

Appendix E - Questionnaire for review board chairpersons

1. Which province does your Review Board represent?

2. How many members did your board have in total at the end of (May), 2002?

3. How many alternate Chairs does your board have?

4. a) Do members of your Review Board currently sit on the Review Boards of other provinces? Yes/No

   b) If yes, how many members currently sit on Review Boards of other provinces? Which province(s) do they go to?

5. Does your Review Board include members from the Review Boards of other provinces? Yes/No

   Which province(s) are they from?

6. Does your Review Board convene
   a) Very frequently (once a week or more)
   b) Fairly frequently (between 1 and 3 times a month)
   c) Occasionally (6 to 11 times a year)
   d) Not very often (1 to 5 times a year)
   e) Rarely (less than once a year)

7. Is provincial legislation in your province relating to this issue expected to change in the near future?

8. Are there any new or unique initiatives or programs in your province relating to mentally disordered persons who come into contact with the justice system? If yes, what are these initiatives or programs?

9. Is there any particular information/data that you believe would be valuable to either your own board or to policy makers/experts in your field relating to mentally disordered persons who come into contact with the justice system?

10. Is there anything you would like to add (i.e. are there any characteristics of your board you would like to highlight or any general issues you would like to raise)?