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On Corrections Research

FORUM

FEATURE ISSUE

Mental Health Care in Correctional Settings

Research in Brief

Legal Perspectives

Release of Inmate Psychiatric Information

Correctional Service Canada
Service correctionnel Canada

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This issue of FORUM is devoted entirely to the exploration of mental health care in penal institutions. The diverse issues examined should reinforce the theory that mental health concerns extend well beyond mental health professionals and their patients. In fact, the promotion of mental health care encompasses every aspect of the offender's social and physical environment.

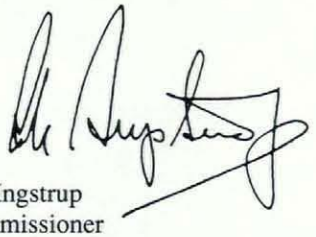
As research projects clearly indicate, mental health care is one of the most serious challenges facing corrections today. A national survey commissioned in 1988 by the Correctional Service of Canada recently reported remarkable findings on the prevalence, nature and severity of mental health problems among male offenders in federal institutions. The Mental Health Survey found that inmates in our institutions have experienced much more mental disorder than was previously understood.

In addition, the 1990 Correctional Service of Canada Task Force on Mental Health Care reported a real need to develop and implement an integrated mental health strategy. Such an approach would involve offenders, mental health professionals, correctional staff, administrators, and the community. The task force report emphasized that offenders need to contribute to the decisions and treatments that affect them in order to assume greater responsibility for their own mental health.

This issue of FORUM provides an indication of the many different research projects on mental health care. The various sections offer an analysis of the mental health services in Canada and abroad. In particular, Chris Webster's feature article invites us to think about mental disorders from an "inverted" perspective.

Mental health care must be a constant concern for policy makers, administrators and front-line correctional staff. We must focus on mental health care not only in the development and implementation of programs but also in day-to-day activities. Research results enable us to create programs that deliver appropriate services and develop a positive environment for offenders.

An individual's mental health can no longer be dichotomized as "normal" or "abnormal." We need to recognize that mental health care is pertinent to all persons in a correctional setting. Concern for the collective and individual mental health of offenders can only assist us in reintegrating them as law-abiding citizens.



Ole Ingstrup
Commissioner
Correctional Service of Canada

Research is often communicated to other researchers only in professional journals that are not typically understood or even read by the people who must put research findings into action. In this section of the magazine we hope to overcome the rift between the researcher and the practitioner by providing brief descriptions of findings from recently published studies. As mental health care is the focus of this issue, we have chosen to highlight research findings in this area. The section looks at mental health care from a variety of perspectives in order to provide a broader understanding of this important subject. More information about the research reported in this section can be obtained by contacting the Research Branch or by consulting the references provided.

We welcome contributions from researchers in the field who wish to have their research findings profiled in the Research in Brief section.

Correctional Staff Perceptions of Disordered Offenders

There has been little research on the perceptions of correctional officers toward mentally disordered offenders. However, the authors of a recent study believe that officer perceptions are extremely relevant to the management of inmate mental health.

Correctional officers, a significant part of the prison environment, may well be able to reduce inmate stress

Correctional officers are in a position to identify offenders in need of mental health services and often to help some of these individuals. In addition, the prison environment has been shown to play an important role in the mental health of inmates. Correctional officers, a significant part of the prison environment, may well be able to reduce inmate stress.

The study evaluated the perceptions of correctional officers toward mentally disordered inmates in order to gather information that could prove valuable in the planning of officer-training programs. The authors hypothesized that correctional officers perceived mentally ill offenders less favourably than mentally ill patients, other inmates, and the population in general.

The participants in the study were drawn from a potential sample of approximately 85 correctional officers employed at the maximum security Vancouver Pretrial Services Centre. Some of the officers could not be contacted because of shift changes or vacation leave. However, all of the 78 officers contacted agreed to participate in the study.

The participants were asked to rate mentally disordered offenders, mentally ill patients, other prisoners and most people in terms of 18 items.

In addition, the study assessed officers' interest in receiving more training to deal with mentally disordered patients. The officers were shown four statements about training and were asked to rate their feelings about each one on a scale ranging from "strongly agree" to "strongly disagree."

The officers also rated their feelings about their professional contact with inmates: A seven-point scale measured the degree to which they felt in control, successful, active, helpful, effective, powerful and confident when dealing with inmates.

Demographic information gathered from the officers revealed no significant links between attitudes and individual variables. The variables examined included age, sex, education, length of employment as a correctional officer, and the perceived amount of contact with mentally disordered prisoners.

The average age of the sample was 32 years, average education was *some* college, and average number of years in corrections was 6.6. On a scale of 1 to 5 (in which 5 represented frequent contact), the average level of perceived contact with mentally ill persons during the previous three months was 3.7.

According to results from the ratings, there were extreme differences between the officers' perceptions of people in general and the other three categories (prisoners, mentally disordered prisoners, and mentally ill patients). The "most people" group was viewed the most favourably, and no further analysis was conducted on officers' perceptions of this group.

Comparisons of the other three groups showed that mentally disordered prisoners were regarded as less predictable, less rational and more mysterious than other prisoners. However, prisoners in general were seen as more manipulative than mentally disordered prisoners.

Almost all the officers were interested in additional training to deal with mentally disordered offenders

A second comparison revealed that mentally disordered prisoners were perceived as more dangerous than mentally ill patients. Finally, mentally ill patients were seen as less bad and less manipulative than prisoners but also as more irrational and unpredictable.

The correctional officers as a group indicated strong concerns about working with mentally ill offenders. Ninety percent felt that it added stress to their job. Eighty-nine percent

thought that mentally disordered offenders should be kept in facilities separate from the rest of the population. Almost all the officers were interested in additional training to deal with mentally disordered offenders. In contrast, they reported that they generally felt confident in dealing with the rest of the inmate population.

One item which discriminated officer perceptions of mentally ill offenders and mental patients was "dangerousness." This perception, or misperception, of the uniform dangerousness of mentally ill offenders would be an important issue for training programs to focus on.

This study clearly indicates that correctional officers have concerns about mentally disordered offenders and would like to improve the ways in which they deal with these offenders.

In the final analysis, it is important to note that, although the participants in this study were trained under the most current programs, they still felt unprepared to deal with the mentally ill. Future research should examine training programs in order to identify the source of gaps in understanding. The perceptions and needs of the people working most directly with mentally disturbed individuals should be addressed.

Studies on whether the presence of mentally disordered inmates is stressful for the rest of the prison population might also be an interesting area of research. In such studies, samples would have to be selected very carefully in order to avoid misclassification of offenders. ■

Kropp, P. Randall, Cox, David N., Roesch, Ronald, & Eaves, Derek (1989). The Perceptions of Correctional Officers Toward Mentally Disordered Offenders. *International Journal of Law and Psychiatry* 1, 181-188.

Patients Held on Lieutenant Governor Warrants

Recent data collected by the Department of Justice Canada show that many individuals held on Lieutenant Governor Warrants have a previous criminal history and previous experience with the mental health system before being placed on warrant.

Information collected beginning in March 1988 shows slightly more than 1,000 patients on Lieutenant Governor Warrants. According to the data, more than one third of these persons had a previous criminal conviction at the time they were placed on warrant.

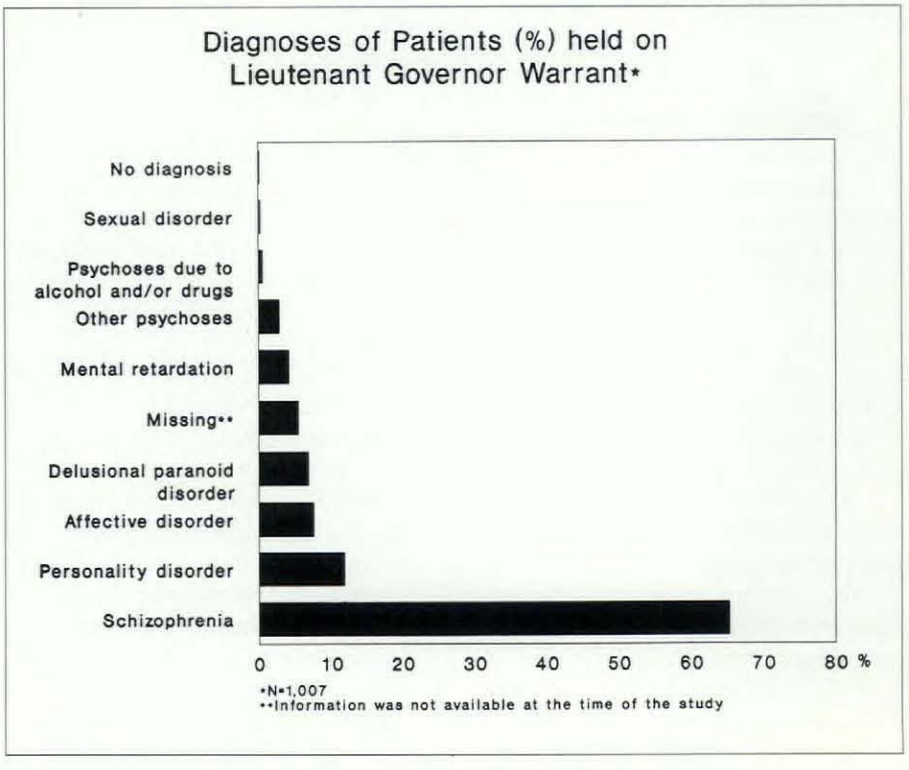
In addition, more than three quarters of patients were previously hospitalized for a mental disorder. Schizophrenia was the diagnosis identified in two thirds of the cases (see figure). Almost 90% of the patients were male, and the average age was 38.9 years.

The Lieutenant Governor Warrant is employed when the accused is deemed unfit to stand trial or is found to have been insane when the offence was committed. The majority of patients held on warrant (nearly 90%) had been deemed not guilty by reason of insanity, and the remaining 10% had been found unfit to stand trial. The warrant was used most often for serious crimes, such as homicide and sexual assault. On average, the patients had been held on warrant for six years.

During the year of the study, more than 300 new patients were placed on warrant and some 251 patients left the system.

The data for the study was gathered from the provincial boards of review. The essential purpose of the data base is to allow for the continuous collection of information on all patients, both new and old. The documentation of the data does not, therefore, represent the completion of the study. Data will continue to be collected during the second and third years of the study.

The findings from the study will be used to assist the Department of



Justice in planning legislative amendments with respect to mental disorders.

The data have broad implications for legal and social research, perhaps even for the Charter of Rights and Freedoms. For example, the length of time that patients are kept on warrant varies considerably from province to province. Many patients are kept longer than if they had been found guilty of the offence and had been incarcerated. Review board hearings also vary from province to province. The majority of patients are not represented by counsel, and in some cases they are not present at the hearing.

Noting the similarities between the psychiatric background of warrant patients and that of many federal patients, the report speculates that the insanity plea may be used arbitrarily. There also seems to be a group of chronic patients who continually move through the legal, health care, and correctional systems. The new data base provides the department with a strong foundation for further study in years two and three of the research project. ■

Hodgins, S., Webster, C., Paquet, J., & Zellerer, E. (1990). Canadian Database: Patients Held on Lieutenant Governor Warrants. Produced under contract for the Department of Justice Canada.

Outcome of Mental Health Treatment in Correctional Settings

It is not uncommon for correctional workers to believe that mental health treatment is largely unsuccessful, that mentally ill offenders should be housed in specialized psychiatric units until completion of their sentence, and that soon after their discharge from such units these offenders will be readmitted.

In order to investigate the validity of these beliefs, M.A. Conroy, a researcher and Chief of Forensics at a federal correctional institution in the United States, conducted a two-phase study from November 1980 to May 1987 to assess the functioning of inmates who had been discharged from the Medical Centre for Federal Prisoners (MCFP).

The MCFP, located in Springfield, Missouri, is the largest of three major mental health units for male offenders in the U.S. federal prison system. It houses a 294-bed mental health service, which is divided into two units — a 178-bed acute in-patient unit and a 116-bed out-patient unit. The centre performs forensic assessments for the federal courts and pre-admission evaluations for the federal system.

Offenders sent to the Medical Centre are carefully screened before being admitted to the in-patient treatment unit. For an offender to be admitted, two of the three clinicians performing the evaluation must agree that the offender suffers from a serious mental illness as defined in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM III), that the offender would be amenable to treatment in an in-patient psychiatric setting and that he could not be treated successfully as an out-patient.

At the time of admission, approximately 75% of the offenders were diagnosed as acutely psychotic. The remainder were situationally depressed, anxious, or suffering from organic disorders

Between November 1979 and May 1987, a total of 2,744 offenders were transferred to the MCFP for evaluation, pending possible treatment. Only 47.3% of those referred for psychiatric treatment were admitted to the psychiatric in-patient unit. The other 52.7% were housed in the out-patient unit for 30 days after the initial assessment, in case additional symptoms should surface. If the offenders showed no further mental difficulties by the end of that time, they were transferred back to the prison.

The majority of the offenders admitted to the psychiatric wing of the MCFP were totally non-functional in the regular offender population prior to their transfer. Others who were transferred to the MCFP were described by the referring institution simply as "too bizarre and disruptive to be allowed in population."

At the time of admission, approximately 75% of the offenders were diagnosed as acutely psychotic. The remainder were situationally depressed, anxious, or suffering from organic disorders.

In phase one of Conroy's study, questionnaires were sent to the receiving institution 60 days after an inmate's discharge from the MCFP. Staff were asked to evaluate the offender's mental health stability and his response to the surroundings.

The results of phase one show that over the 7 1/2-year period studied, 78% to 90% of those who were reintegrated into a regular correctional setting after receiving treatment at the MCFP were considered by the staff to be functioning well in the institutional setting. Similarly, according to assessments by the institutional psychologists, 88% to 98% remained mentally stable or improved their mental health condition.

The second phase of the study, conducted between 1984 and 1987, evaluated the effectiveness of the treatment received at the MCFP in-patient unit. Questionnaires were sent

to the prison six months after the offender's discharge. Questions were asked about the offender's job performance, maintenance of quarters, social interaction with other inmates, behavioural records, follow-up care if applicable, and ability to remain in the regular population.

Results for the four-year follow-up period indicate that 87% to 100% of the discharged patients received average or above-average work appraisals; between 90% and 96% were considered average or above average with respect to the tidiness of their cells; 63% to 79% were rated by their case managers as average or above average in social skills; only 8% to 9% were convicted of two or fewer disciplinary offences, with the majority receiving none; and 73.9% of the offenders were undergoing follow-up care in the six months after their discharge.

An interesting observation, especially in view of the fact that most of the offenders treated at the MCFP had been segregated from the rest of the offender population prior to their transfer, is that the majority did not request or require to be isolated in the six months following their discharge from the MCFP.

Another interesting finding is that, of the 2,744 offenders transferred for evaluation or treatment at the MCFP during the 7 1/2 years of the study, only 173 were readmitted.

The general findings of the Conroy study indicate that after treatment in a psychiatric facility, offenders suffering from mental and behavioural disorders can benefit further from continued treatment for the remainder of their sentence in a regular correctional setting.

Over the past year, Conroy has extended his research to include a follow-up of offenders who were released to other agencies or to the community after receiving treatment. ■

Conroy, M.A. (1990). Mental Health Treatment in the Federal Prison System: An Outcome Study. *Federal Probation,* March, 44-47.

Study Stresses Co-ordination of Mental Health Services

A recent study has determined that interjurisdictional and jurisdictional co-operation patterns produce positive results within forensic mental health services in Canada.

The study reviews and compares the forensic mental health services of the ten provincial and two territorial jurisdictions. The term "forensic mental health services" refers to the mental health services available to individuals who have become involved with the criminal justice system.

Each jurisdiction was asked to describe its present services as well as areas in which it might be lacking services. Information about mental health services within the federal system is provided by the author, as he is employed by the Correctional Service of Canada.

After reviewing both the federal and provincial systems, the study concludes that more could be done in the area of interjurisdictional co-operation. The author cites some positive examples already in existence, including the provision of services to the province of Saskatchewan by the federally operated Regional Psychiatric Centre in Saskatoon and the provision of services to the Correctional Service of Canada in Quebec by the Institut Philippe Pinel. The study recommends that all jurisdictions work together to reduce duplication and improve the utilization of existing resources.

In addition, the author emphasizes that better communication patterns seem to be fostered within jurisdictions where one individual co-ordinates the forensic mental health services. He suggests that the designation of a co-ordinator gives all employees a legitimate channel for communicating thoughts and concerns about forensic psychiatric services.

Currently, only British Columbia and Manitoba have centralized forensic mental health services co-ordinated by one person. The author found the most impressive organizational model to be British Columbia's Forensic Psychiatric Services Commission.

The author makes several other general observations after reviewing the information received. A basic level of mental health service (psychologist, visiting psychiatrist or crisis intervention) is available in most institutions of the Correctional Service of Canada. Intensive in-patient service is available in the Regional Psychiatric Centres in Abbotsford and Saskatoon, the Regional Treatment Centre in Kingston, and (through contract) the Institut Philippe Pinel in Quebec. In addition, the Atlantic Region has a 12-bed psychiatric unit in Dorchester Penitentiary and is currently studying a major redevelopment plan.

The study found that a great variety of forensic mental health services exist in provincial jurisdictions. The author concludes that there is no "ideal" model of service. He notes, however, that while services must be implemented to address the needs of individual jurisdictions, the needs of other jurisdictions must also be taken into consideration.

When surveyed for their views on the proposed changes to the Criminal Code and on the implications of the Canadian Charter of Rights and Freedoms, the jurisdictions expressed a variety of different concerns, and there was thus no clear consensus on these issues. ■

Gillies, R. (1990). Comparative Analysis of Forensic Mental Health Systems in Canada. Prepared for the Canadian College of Health Service Executives as a requirement for Fellowship.

Understanding the "Disturbed Violent Offender"

Disturbed violent offenders have presented a daunting challenge to researchers, partly because they are a difficult group to isolate and study. Many crimes committed by disturbed offenders are no different from those committed by non-disturbed offenders. In addition, the links between mental health problems and violence vary, even in a single individual.

In their recent book, *The Disturbed Violent Offender,* Hans Toch and Kenneth Adams provide both a systematic overview and a typology of violent offenders who have a history of mental health problems.

According to the authors, the aim of typologizing violent offenders is to allow interested observers of these persons to "think about them more easily and compare them along attributes that are of concern to themselves and their colleagues."

Toch and Adams began their study by identifying offenders who had been convicted and sentenced to the New York prison system between January and December 1985.

Offenders with mental health histories, in particular substance abusers, had "much more extensive criminal records" than did other offenders

During that period, 8,379 of the 12,764 offenders admitted to the prison system were convicted of statutorily defined violent offences. These included a few crimes that traditionally might not be considered violent, as in New York State there are degrees of burglary and robbery to identify situations in which the victim was threatened or physically harmed.

The authors proceeded with their sample selection by matching the names of violent offenders with client records maintained by the New York State Office of Mental Health. The records are a listing of all persons who have received out-patient or in-patient treatment at a state-operated psychiatric facility. The analysis yielded a total of 1,833 matches. The treatment history of each individual was then obtained in order to "infer the nature and severity of mental health problems."

The authors then approached the New York State Department of Correctional Services. Information gathered during the inmate intake and classification process detailed past mental health involvement and criminal history. Material gathered from the correctional files provided new information on the nature of treatment for some forensic patients whose history had been unknown and some mental health patients who had not previously been identified as such.

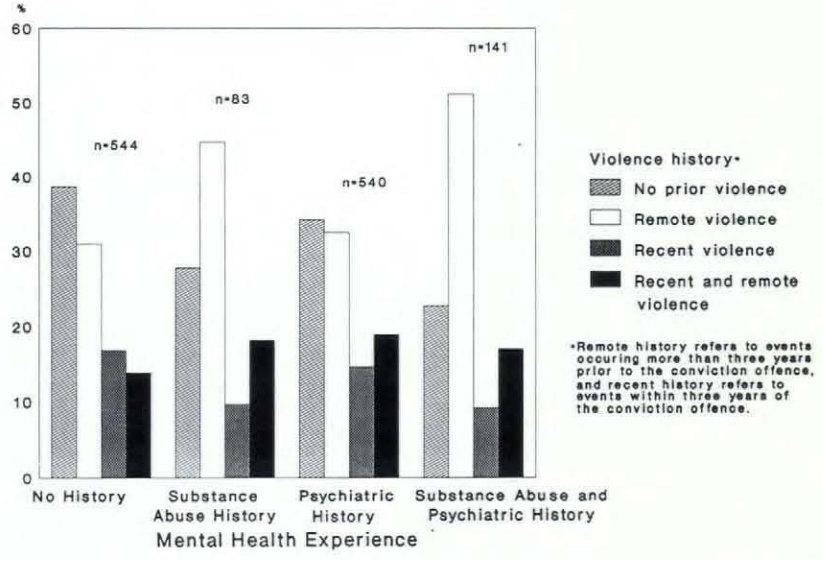
A sample of 1,307 offenders was divided into three categories of mental health experience — substance abuse (n=83), psychiatric (n=540), and combined psychiatric and substance abuse (n=141). Offenders with no history of mental health treatment or with unverified treatment data became the comparison group (n=544).

The statistical analyses yielded a number of specific results. For example, offenders with mental health histories, in particular substance abusers, had "much more extensive criminal records" than did other offenders. The data also indicated that offenders with psychiatric histories were one-and-a-half times more likely than the comparison group to have been arrested for assault offences.

Substance abusers showed a greater likelihood of convictions for possessing or selling drugs and driving while intoxicated. This group also had a propensity for burglary and property offences. All groups of offenders with mental health histories showed greater involvement in nuisance offences than did the comparison group.

The results also indicated a connection between substance abuse and type of crime. Alcoholics had a

Career Patterns of Violence History
by Mental Health Experience of Offender



greater likelihood of engaging in arson, assault, reckless endangerment, public order offences and intoxicated driving. In contrast, drug addicts were more likely to commit burglary and drug offences, including marijuana offences.

As the figure indicates, the group with no history of mental health treatment (comparison) had the highest proportion of offenders with no violence history (38.5%), while the substance abuse and psychiatric group had the lowest proportion (22.7%).

In addition, the substance abuse history group and the substance abuse and psychiatric history group tend to have histories of violence limited mostly to the remote past (44.6% and 51.1% respectively). All three mental health groups show greater chronicity of violence than does the comparison group, with the psychiatric group showing the most evidence of both recent and remote violence (18.9%).

After providing a detailed overview of disturbed violent offenders, the authors turn to the second part of their research task — creating offender typologies.

Offender Typologies

The four groups (psychiatric, substance abuse, psychiatric and substance abuse, and comparison) are divided into a number of typologies, for example, impulsive burglar, addicted burglar, mature mugger, disturbed sex offender, alcohol exploder and skid row robber.

Toch and Adams note that while the comparison sample cannot be classified as disturbed, neither can it be classified as "mentally healthy." The authors emphasize that a continuum exists from mental illness to mental health and that movement along the continuum can be a goal of intervention.

Throughout their analysis, the authors stress that mental health problems and offence behaviour change over time, as do the relationships between the two. To organize this developmental complexity, the authors refer to an offence-mental health "career," meaning the patterns of experience that are common to groups of individuals.

The goal of the research was to illustrate patterns of behaviour in which the "advent of criminal acts and of symptoms that are serious enough to justify diagnosis and treatment can be located in time." In this way, offenders could at various times be shown to be unambiguously disturbed, engaging in crime, or both.

Differentiating an offender's patterns of behaviour into career "segments" is useful for treatment programs. For example, offences that are committed consistently after the completion of programs have different implications than those that occur when the offender is receiving mental health services or when the offender has not yet been diagnosed.

Sentencing and Programming Concerns

In concluding their study on disturbed violent offenders, the authors examined the problem of sentencing the "extremely disturbed but minimally violent offender" and the problems of programming for the "extremely disturbed and extremely violent offender."

As Toch and Adams see it, the problem with sentencing is that some inmates are primarily disturbed and secondarily offenders but are processed as if they were primarily offenders and secondarily disturbed. Mentally ill persons are deprived of treatment, and, what is worse, must now function in a difficult setting with limited coping capacities. (For further discussion, see H. Toch, *Men in Crisis: Human Breakdowns in Prison*, 1975).

One of the programming concerns is the fact that the disturbed violent offender does not fit well into the contemporary hospital setting. Offenders cannot leave the hospital until they are determined to be no longer dangerous, even if they are no longer considered disturbed.

In prison, the disturbed offender faces two particular problems: Prisons require participation in most prison routines (such as adherence to instructions and involvement in programs), and they require close co-habitation in a setting where eccentricity is not appreciated.

Toch and Adams stress that prisons must "determine to what extent they are in the business of providing mental health assistance." They readily admit that this is not a simple distinction, as there are no clear lines drawn between rehabilitation and mental health services.

The differentiation of offenders into homogeneous groups allows for the creation of a therapeutic community for offenders with similar problems. Toch and Adams also advocate a special setting for troubled or disturbed inmates within the prison environment. Autonomy introduces flexibility and allows for some relaxation of routines if necessary. To eliminate the departmentalization of mental health and correctional staff, Toch and Adams suggest "staff teaming," encouraging both groups to work together. Inmates also benefit from this teaming because they avoid the "sick" label that comes with being treated by mental health staff.

The authors believe there is a need for experimentation with interface arrangements such as those proposed in this study. The disturbed violent offender requires interdisciplinary attention and interagency collaboration. Above all, institutions must provide programming and services that are sensitive to the complexity of individuals.

Further research is needed to develop models that respond to the multiproblem offender. The work of Toch and Adams should stimulate more interest in this exciting and relatively unexplored area. ■

Toch, H., & Adams, K. (1989). *The Disturbed Violent Offender*. Binghamton, New York: Vail-Ballou Press.

Pharmacotherapy

Certain drugs can have a positive effect on controlling violent behaviour, whereas others are often directly associated with aggression. Neil Conacher, a Canadian psychiatrist, reviews the literature on general pharmacological approaches to aggression while focusing on three classes of drugs (lithium, propranol and carbamazephine) with familiar clinical applications. Recently, these drugs have been examined for their effects on aggressive behaviour.

Lithium is now well established as a safe and effective treatment for various forms of affective disorders, provided certain recognized guidelines are followed (e.g., the monitoring of serum levels). The anti-aggressive action has been demonstrated on various clinical conditions, including chronic psychosis, mental retardation and personality disorder. Recent research has concluded that lithium can inhibit self-injury of individuals who show uncontrolled self-directed aggression. As well, lithium may produce a beneficial response in institutionalized subjects with violent behaviour disorders. Lithium appears particularly effective on states of aggression in individuals in whom violence is easily triggered, regardless of the diagnosis.

The various types of propranol have been reported to have anti-aggressive effects on, among others, violent chronic schizophrenics and a small number of violent male patients with organic brain disorders.

Carbamazephine is now the preferred drug for treating temporal lobe epilepsy and is increasingly recognized as a complement or alternative to lithium for certain types of disorders. It may also be beneficial in treating uncontrolled outbursts of rage. However, serious side effects have been reported.

Because all three of the above-mentioned drugs have a complex range of biological effects, Conacher notes that it has not been possible to correlate any of their particular properties with their behavioural efficacy.

Conacher also reinforces the idea that a pharmacotherapy approach is only effective if it complements other social and behavioural treatment. He adds that further research should not be limited to whether aggressive patients respond to pharmacotherapy. The question to be considered now is what kinds of aggressive patients respond to which medication. ■

Conacher, N. (1988). Pharmacotherapy of the Aggressive Adult Patient. *International Journal of Law and Psychiatry* 11, 205-212.

Workshop on Psychopathy Highlights Need for Appropriate Intervention

Therapeutic community treatment programs can inadvertently increase the recidivism rates of psychopaths, according to two independent studies discussed at the annual Canadian Psychological Association convention held in Ottawa, Ontario, from May 31 to June 2, 1990.

A follow-up study of a therapeutic community program that operated out of Penetanguishene approximately 10 years ago has found that psychopaths who completed therapy recidivated at a higher rate than those who had not received any therapy. Penetanguishene is a maximum security mental health centre in Ontario.

The authors of this study, Grant Harris and Marnie Rice, are employed at the research department in Penetanguishene. In his presentation of the study, Harris offered a possible explanation for the increased recidivism of psychopaths: The peer interaction, open communication style, and lack of staff intervention typical of the therapeutic community approach may have reinforced skills that psychopaths could use for antisocial purposes after release.

However, in the Penetanguishene study, the therapeutic community treatment program seemed to have some positive effects on the non-psychopathic participants. This is an interesting finding, as non-psychopathic inmates were not targeted for improvement, but were included in the group only to create a mixed environment for peer interaction.

It is also noteworthy that the follow-up study used a different definition of psychopathy than did the original study. The original study defined psychopathy according to the clinical impressions of the psychiatrists, whereas the recent study employed Hare's 20-item Psychopathy Checklist (PCL) as its measure. Examples of some of the items on the checklist are: glibness/superficial charm, shallow affect, criminal versatility, and grandiose sense of self-worth.

When the PCL was applied retrospectively to the extensive file information available on each program participant, about one third of the group originally classified as psychopaths no longer fit that designation.

The results of another study on a therapeutic community program, at the Regional Psychiatric Centre in Saskatoon, also indicate that such programs may be inappropriate for psychopaths. Stephen Wong and James Ogloff found that psychopaths showed less clinical improvement, displayed lower levels of motivation and were discharged from the program earlier than both a non-psychopathic group and a mixed group. The psychopaths were often discharged from the program for security reasons. Scores from the PCL consistently postdicted and predicted treatment outcomes.

In his discussion, Wong said that

in his experience, the treatment sessions, rather than teaching psychopaths to empathize with others, taught some of them how to manipulate human vulnerabilities and insecurities.

Wong concluded his talk by saying that psychopaths should not be put into a situation in which they gained a better understanding of the "human psyche." Instead, counselling for psychopaths should appeal to their egocentricity, by stressing the disadvantages of another term of incarceration as a result of a return to illegal activities.

In another study, Vernon Quinsey, Marnie Rice and Grant Harris conducted a follow-up of rapists assessed at Penetanguishene. Recidivism and readmission data were gathered over an average 46-month follow-up period on 54 rapists released from Penetanguishene. The results of the study indicated that sexual recidivism and violent recidivism were well predicted by degree of psychopathy and by phallometrically measured sexual interest in non-sexual violence.

Overall, the symposium very clearly demonstrated the gains that have been made in the understanding of psychopathy. Robert Hare's Psychopathy Checklist provides clinicians with systematic guidelines to differentiate criminal psychopaths and non-psychopaths, while eliminating much of the bias associated with individual clinical assessments.

Robert Hare pointed out that as psychopaths are considered to be pathological liars, the PCL is more reliable than self-report inventories in attempting to determine the presence of psychopathy. According to the Harris study at Penetanguishene, the PCL is also reliable when used by raters if they have had some training in using the measure.

The rater reliability of the PCL was also shown in a French-language study recently completed by Gilles Côté at the Institut Philippe Pinel, in Montréal. Côté reported that the reliability results of his study were comparable to other Canadian studies that used the English version of the PCL. The predictive validity of the French version of the checklist is currently under review.

To further assess the implications of the PCL within the criminal justice system, Ralph Serin (Joyceville Institution, Ontario) reported on two independent research projects using the checklist. In a five-year follow-up study, he found that the PCL significantly predicted recidivism and violent recidivism rates in a sample of psychopaths, non-psychopaths, and a mixed group.

In his second study on the relationship between criminal psychopathy and violence, Serin demonstrated that although the two were not synonymous, they were strongly related. The study found that violent psychopaths were more likely than violent non-psychopaths to use threats and weapons. However, there was no demonstrable difference between the two groups in terms of seriousness of offence.

The psychological community continues to debate the question of whether or not psychopaths are treatable, but psychologists now have an assessment measure that seems to be reliable in predicting pre- and post-treatment outcomes of psychopathy.

Treatment programs may not always produce positive or neutral results. The Penetanguishene retrospective study highlights the consequences of inappropriate intervention. Future research may find that highly structured intervention may be a more successful treatment for psychopathic clients.

But therapeutic community treatment should not be dismissed simply because it does not seem to benefit psychopathic persons. The treatment was found to have positive results on the non-psychopathic patients in the Penetanguishene study. In brief, appropriate intervention is the key to successful treatment programs.

The two studies also point out the importance of an initial classification of inmates. Like Toch and Adams's classification system for disturbed violent offenders (see Research in Brief, "Understanding the 'Disturbed Violent Offender'"), Robert Hare's Psychopathy Checklist differentiates between offenders so that inappropriate treatment programs can be avoided. The value of these classification systems will only increase as psychologists develop new ways to use them in the creation of treatment programs. ■

Gilles Côté, Robert Hare, Grant Harris, Ralph Serin, Vernon Quinsey and Stephen Wong spoke at a symposium entitled "Psychopathy and the Criminal Justice System" at a convention of the Canadian Psychological Association on Friday, June 1, 1990.

Reduction of Self-Injury: A Mental Health Priority

A recent study at the Kingston Prison for Women addresses three areas related to self-injurious behaviour — injury response, injury reduction and suicide identification. These three areas were identified by a February 1989 preliminary study as major issues requiring examination.

The study is based on the understanding that "self-injurious behaviour is a coping strategy that manifests itself as a result of childhood abuse (usually sexual)." The recommendations from the study have been used in the development of a therapeutic program for inmates who self-injure at the Kingston Prison for Women.

According to the model developed in the preliminary study (see insert), self-injurious behaviour is an attempt to reduce anxiety. In the light of this model, the study found that the

Self-Injurious Behaviour as a Coping Strategy

The model purports that "the dynamics of (childhood) sexual abuse lead to self-blame by the victim as a method for believing that she has some control in a powerless situation." This phenomenon is a result of the victim's ambivalent feelings toward the abuser (often a significant other) and the blatant or subtle threats made by the abuser.

Continued abuse, coupled with the victim's use of self-blame as a coping strategy, results in her belief that bad things do and will happen to her. This belief in an inevitable "badness" leads to extreme anxiety, sometimes experienced as "deadness" or "numbness."

Self-injurious behaviour is an attempt to control the timing and extent of the anticipated pain. Once the act of self-injury is carried out, the anxiety level is immediately reduced. Self-injurious behaviour can therefore be seen as an "adaptive" and "resourceful" behaviour in that it decreases anxiety. ■

prison policy on response to self-injury was, at best, not helpful and, at worst, detrimental to the prisoner's mental health.

Information about self-injurious behaviour was gathered through interviews with prisoners, security personnel and other relevant groups. In a sample of 44 prisoners, 74% reported they had been victims of child abuse. Of this group, 50% said they had experienced both sexual and physical abuse, 28% reported only sexual abuse, and 22% reported only physical abuse. The study notes that these figures should be considered conservative because some women are reluctant to reveal sexual abuse to an unknown interviewer, and some use silence as a defence mechanism to cope with childhood sexual assault.

Twenty-six (59%) of the 44 prisoners interviewed reported that they were engaging in, or had engaged in, self-injurious behaviour. Of this number, 73% reported childhood abuse

Of the women who reported being abused as children, 76% said they still experienced emotional difficulties as a result of the abuse.

Twenty-six (59%) of the 44 prisoners interviewed reported that they were engaging in, or had engaged in, self-injurious behaviour. Of this number, 73% reported childhood abuse. These figures are considered conservative for the reasons noted above.

Despite the figures obtained from the interviews, it is difficult to determine the extent of the problem of self-injury at the Kingston Prison for Women. For example, not all of the women who reported instances of self-injurious behaviour had engaged in such behaviour recently or on a regular basis. Clearly, however, self-injurious behaviour is a problem for a large number of female offenders at some point during their incarceration.

According to the model, the action of self-injury is the culminating point of a crisis. It is unlikely, therefore, that a prisoner will self-injure again soon afterward. However, prisoners who self-injured at the women's prison were placed in segregation immediately after leaving health services. They remained in segregation so that they could be monitored until being assessed by a psychologist. Often, prisoners spent the night or weekend in segregation. Isolation only increased the chances that the cycle of anxiety would begin once again.

Although prisoners were not questioned directly on the appropriateness of segregation, 39 of the 44 prisoners interviewed addressed the issue. Of these prisoners, 38 argued that segregation was an inappropriate response. Many of the prisoners perceived the transfer to segregation as a form of punishment.

Prisoners were also questioned about suicidal behaviour, although the author emphasized that self-injurious and suicidal behaviours should not be equated. However, many of the recommendations regarding self-injurious behaviour were also applied to suicidal behaviour, especially the recommendation that individuals not be placed in segregation.

Therapeutic Program

The results of this study are guiding the development of a therapeutic program for women who self-injure at the Kingston Prison for Women. The study indicates that the most effective approach to reducing self-injurious behaviour is to treat its occurrence as a sign of emotional distress, rather than an issue of security. Responsibility for its reduction should thus be shifted from security to counselling personnel.

The study also reveals that women who self-injure often seek emotional support from their peers, and it recommends that this support be "acknowledged" and "legitimized" through the development of a program to train prisoners as peer counsellors.

As the model implies, reducing self-injurious behaviour involves

replacing attempts to control with more constructive coping strategies. But until these strategies are learned, programs should strive to increase the woman's feeling of self-control.

The therapeutic program of peer counselling tries to address the factors that prisoners reported as causes of self-injury (such as situations that produce feelings of isolation and powerlessness), and focuses on counselling issues.

The therapeutic program allows a team of 11 inmate counsellors to be available to prisoners on a 24-hour basis. In addition, support and ongoing training are available to counsellors throughout the program.

The program is a viable solution to the logistical problems of obtaining 24-hour access to one of the prison's two psychologists and provides the means to tap into an existing support system. It also relieves some of the pressures placed on correctional staff, who are expected to prevent and deal with cases of self-injury even though they have no psychological training.

The therapeutic program tries to utilize available resources to ensure the optimum mental health of prisoners. The study demonstrates that programs must target the causes, and not just the visible manifestations, of a problem. In addition to facilitating the implementation of a therapeutic program, the study has highlighted the need for future research projects on the effectiveness of inmate support systems. ■

Heney, J. (1990). Report on Self-Injurious Behaviour in the Kingston Prison for Women. Submitted to the Correctional Service of Canada.

A Five-Year Historical Profile of Canadian Regional Psychiatric Centres

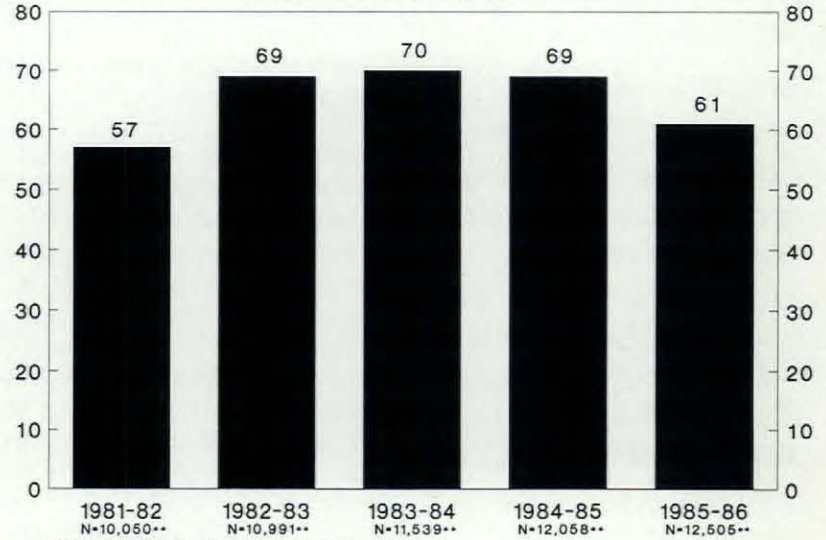
To provide some findings on mental health services in Canada, the Research Branch examined data contained in the Medical Health Care Services annual reports for the fiscal years 1981-82 to 1985-86. The reports include data from the two Regional Psychiatric Centres, the Regional Treatment Centre, and an outside psychiatric facility (Institut Philippe Pinel). These findings are the most recent data available, as the annual reports were discontinued after 1985-86.

We have compiled a brief overview of findings on offenders and psychiatric facilities. Figure 1 indicates that the admission rates remained fairly stable over the five-year period. However, the average occupancy of beds in the three major psychiatric facilities — Regional Psychiatric Centre (Prairies), Regional Psychiatric Centre (Pacific) and Regional Treatment Centre (Ontario) — increased dramatically, from 67% in 1981-82 to 90% in 1983-84, and then remained stable until 1985-86. This can be explained by the increase of approximately 20% in the general offender population.

Personality disorder was the most common diagnosis cited as the reason for offender discharge, as shown in Figure 2. Psychotic disorders accounted for about 20% of all diagnoses in the entire five-year period. There appears to have been no increase in the number of offenders diagnosed as sexual deviants upon discharge. The drop in substance abuse diagnoses from 1983-84 (20%) to 1984-85 (5%) may be due, at least in part, to the change in disorder classification between years.

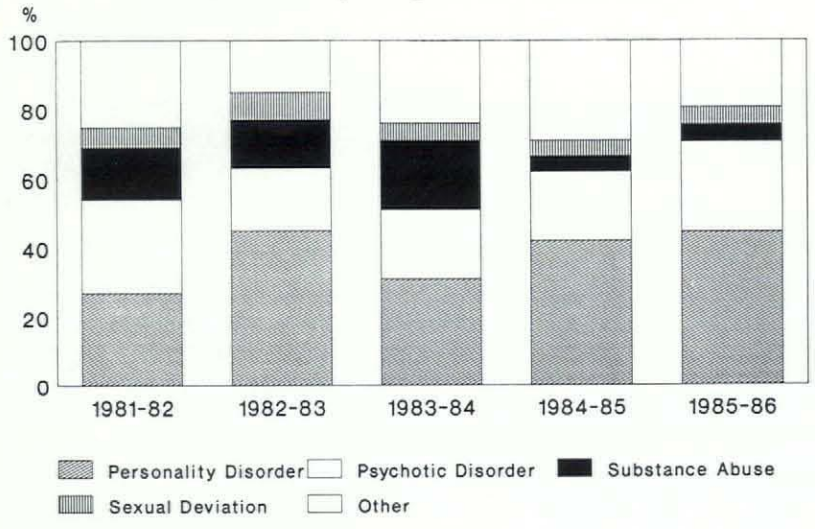
In providing a snapshot of the trends over a period of time, historical analyses can assist us in present

Figure 1
Admissions to Major Psychiatric Centres*
Rates per 1,000 Offenders in
Federal Institutions (1981-86)



*Pinel, RTC Ontario, RPCs Prairies and Pacific
**Offenders on register in federal correctional institutions

Figure 2
Discharged Cases from Regional Psychiatric Centres by Diagnoses* (1981-86)



* Pinel Centre is included for each year
1981-82 does not include Pacific or Prairies region
1983-84 does not include Pacific region

situations by giving us a better understanding of offenders who require mental health services. ■

Operational Statistics: Institutional Health Care Centres and Major Psychiatric Facilities. Medical and Health Care Services, Correctional Service of Canada, 1980-86.

On the Willful Induction of Mental Disorder

By Christopher D. Webster
Clarke Institute of Psychiatry

The Correctional Service of Canada has recently acquired dependable new data on the prevalence of various kinds of mental disorder in the federal system. These were sketched in a previous issue of this periodical.[1] *Readers learned, for example, that members of the Canadian offender population had a one-in-ten risk of being psychotic at some time during their lives and a one-in-four chance of suffering from a psychosexual disorder. The article pointed out that one in five met the dual diagnosis criteria of antisocial personality and alcohol abuse or dependence. It also appeared that offenders with a "criminal profile" were particularly likely to be mentally disordered.*

The availability of such baseline data makes it possible to consider how to reduce the general level of mental disorder. Alternatively, it is now within our power to consider how the level might be increased. *As reader, you may ask why the Service would want to* raise *the already high incidence of mental disorder. Of course, no sensible organization would wish for such a result. Yet, there is something to be gained from "inverting" a problem — as I will do in this article.*

This type of argument follows good precedent: In his utopian novel *Erewhon*,[2] Samuel Butler helps us understand something about psychopathy and personal responsibility. He invents a world in which people who admit to physical ailments are chastised and punished, whereas those who confess to moral disorders (such as drinking and fraud) are met with kindness and helpfulness. Those unable to resist the temptations of the flesh are sympathetically assisted by the "straighteners," but those in physical pain are beaten or imprisoned. Butler uses this approach to help us see important moral and political issues in an entirely new light.

A little closer to home perhaps, we have the article by Jay Haley published in the *American Journal of Orthopsychiatry*.[3] This piece instructs psychotherapists on how to fail. Haley argues, tongue in cheek, that since people have a remarkable ability to recover from mental disorders spontaneously, it takes skill and cunning to keep a patient needlessly in therapy. The recovering patient has to be convinced that if one symptom is relieved, a worse one will develop, that improvement is not improvement but a "flight-into health," and so on. He outlines the steps that a fully proficient therapist can take to keep a client in treatment for years. In this at once amusing and instructive article, Haley intended for his points to be reversed in order to provide a helpful outlook to would-be therapists. My aim here is similar. Let us think of how the Correctional Service of Canada could raise the level of mental disorder by 1% annually until the year 2000. Here are a few ideas.

1. Definition

Mental illness can be induced in all manner of ways. There are highly effective means of promoting disorder in the individual. As will be shown in section 2 below, simple isolation and outright neglect work wonders. But this is small stuff and takes a lot of time. If senior administration intends to be efficient in raising the general level of mental disorder, it needs to undertake major actions. It is a good idea, for example, to pressure for provincial mental health legislation with very narrow and restrictive definitions of mental disorder. As a result, doctors cannot or will not certify patients. The police eventually tire of taking the troubled and troublesome to the hospital emergency rooms and lay charges instead. Such criminalization of the mentally ill is one of the best and surest ways of raising the overall level of mental disorder in provincial and federal corrections. It is exciting to think that mental disorder can be legislated and planned for and that the numbers can be forced up by such delightfully indirect means. If general mental health services are reduced or made inaccessible, it is possible to guarantee a rise in the prison incidence of psychiatric disorder.[4]

2. Isolation

Once persons are in the system, they need to be kept there. This takes some effort; otherwise, many will recover, and misguided judges will let them go free. Facilities for the mentally ill within remand centres should be kept in disrepair, with minimal attention to hygienic and recreational considerations. Doctors should be kept out of these places as much as possible. If they do see prisoners and prescribe medication, the prisoners should, under no circumstances, receive the medication. Lack of medication and utterly dreary conditions will avert any risk of psychiatric normality. The general principle here is to isolate the mentally disordered offender from the

[1] *Correctional Service of Canada (1990). "A Mental Health Profile of Federally Sentenced Offenders,"* Forum on Corrections Research *2, no. 1, 7-8.*
[2] *Butler, S. (1967).* Erewhon. *New York: Airmont. (First published anonymously in 1872.)*
[3] *Haley, J. (1969). "The Art of Being a Failure as a Psychotherapist,"* American Journal of Orthopsychiatry *39, 691-695.*
[4] *Penrose, L. (1939). "Mental Disease and Crime: Outline of a Comparative Study of European Statistics,"* British Journal of Medical Psychology *18, 1-15.*

rest of humanity.[5] A good deal can be achieved simply by having the person seen as a "nut case" or "screwball." Fellow inmates and staff can be very helpful in ensuring that a person gets off on the right foot in establishing a career as a mentally ill offender. Once the career has begun, it can gain a momentum of its own.

3. Invention

Deviant psychological and sociological researchers[6] have recently pointed to the fact that some mental health workers routinely "construct" or amplify mental disorder and dangerousness. This is done largely from files, which progress from pretrial assessment to presentence reports to institutional reports to parole reports. They are like snowballs coursing down a hill. They incorporate more and more information, much of it unacceptable by ordinary evidential standards. Some, but unfortunately not all, mental health workers have a keen literary bent, which can be put to good use in creating new stories from the record.[7] These stories offer intelligent, if fanciful and untestable, hypotheses about the origins of mental disorder, propensity for violence, and the like. The process has been referred to as "laundering."[8] The theories of deviant researchers such as those referred to above must be discredited with passion and invective. When they dare attempt to discuss the actual rather than apparent role of mental health workers in the "construction" of mental disorder, they can be "tormented"[9] and said to be inept or even unethical.[10]

4. Misapplication

Psychiatrists have great power to increase the magnitude of perceived mental disorder. Many categories of illness have been added over the years with the slow evolution of the 1987 edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM III-R). This in itself is helpful to the cause espoused here. But psychologists too have their own peculiar resource — their tests. Some of these tests undoubtedly measure what they are supposed to measure and do so well when properly administered and standardized. Such tests are undesirable. What is needed instead is misapplication, which often inflates the level of disorder or mental handicap.[11] Psychologists should be encouraged to test groups of individuals in uncomfortable, pressured circumstances, with instruments designed for individual application. They should be invited to make wide-ranging interpretations from projective and non-projective tests. Ideally, these tests are never standardized for correctional populations. Some of the brighter psychologists should be encouraged to invent new tests of their own and use the eventual scores to make far-ranging decisions about their clients' futures. It goes without saying that these tests should be quite sophisticated and subtle. No ordinary person should be able to see any connection between the test or scale items and any practical consideration.

5. Aprogramming

This point is related to the one above. If some of the psychiatrists and the most of the psychologists are kept busy "doing assessments" and the like, few will have the time or energy to develop remedial programs. Vigilance is needed to avoid these remedial programs at all cost. People like Andrews, Bonta, Gendreau, Ross, Wormith, and Wong can yet do damage by injuring Martinson's well-founded cause. As there is every reason to believe that mental disorder increases in the absence of well-run vocational, educational, recreational, and remedial programs, such innovative programs must be seen as impediments. It is indeed fortunate that it is very hard to establish such programs in institutions and communities, and that if they somehow take root, there are many ways to undermine them. Should results indicating the positive effects of treatment ever get into print, they can, of course, be discredited.[12]

[5] *Mohelsky, H. (1982). "The Mental Hospital and Its Environment,"* Canadian Journal of Psychiatry *27, 478-481.*

[6] *Menzies, R. (1989).* Survival of the Sanest: Order and Disorder in a Pre-Trial Psychiatric Clinic. *Toronto: University of Toronto Press. Pfohl, S. (1979).* Predicting Dangerousness: The Social Construction of Psychiatric Reality. *Lexington, Mass.: D.C. Heath. Konecni, V., Mulcahy, E., & Ebbeson, E. (1980). "Prison or Mental Hospital: Factors Affecting the Processing of Persons Suspected of Being 'Mentally Disordered,'" in* New Directions in Psycholegal Research. *New York: Van Nostrand Reinhold.*

[7] *Pollock, N., McBain, I., & Webster, C. (1989). "Clinical Decision Making and the Assessment of Dangerousness," in* Clinical Approaches to Violence. *Chichester: Wiley.*

[8] *Monahan, J. (1981).* Predicting Violent Behavior: An Assessment of Clinical Techniques. *Beverly Hills, Calif.: Sage.*

[9] *Webster, C. (1980). "The Old Torments: How to Defeat the Colloquium Speaker,"* Canadian Psychology *21, 90-92.*

[10] *Rogers, R., & Bagby, R. (1990). "Book Review: Survival of the Sanest: Order and Disorder in a Pre-Trial Psychiatric Clinic,"* Health Law in Canada, *251-254.*

[11] *Derkowski, G., & Derkowski, K. (1985). "Mentally Retarded Offenders in the State Prison System: Identification, Prevalence, Adjustment, and Rehabilitation,"* Criminal Justice and Behavior *12, 55-70.*

[12] *Andrews, D. (1989). "Recidivism Is Predictable and Can Be Influenced: Using Risk Assessments to Reduce Recidivism,"* Forum on Corrections Research *1, no. 2, 11-18 (see especially p. 18).*

6. Uniformity
The only thing that may be more successful than the absence of programming in promoting mental illness in prisoners is the adoption of a single-minded, and preferably simple-minded, approach to habilitation.[13] Properly effected, this method has a prophylactic effect. A mental health professional new to the correctional sphere can enter with a "sure-fire" approach.

Administration accepts the plan because of sloth or inattention, and the project commences. It matters little what the idea is: token economies made to look novel, sex-drive-reducing medications, alteration of criminal thinking patterns. The program should not take into account any theoretical ideas of the prisoners about addiction, psychopathy, sexual disorders or major mental illness.[14] If there is no consideration of individual therapeutic requirements, failure is virtually assured. Mentally ill prisoners need experience with failure if they are to get worse.

7. Discontinuity
Inevitably, a deviant administrator, planner or researcher will occasionally get the idea of constructing a set of integrated, individually tailored programs with careful bridging between components. Fortunately, links in such a chain are seldom forged and are easy to break. It is almost assured that a schizophrenic prisoner will relapse if removed abruptly from a well-regulated therapy program and medication. There is a reasonably good chance that a sex offender treated in a Regional Psychiatric Centre can be induced to relapse by simply being discharged to the street without professional support.[15] Not only is the patient's problem reconfirmed, but there is a possibility that those directly affected by the illness or impulsive acts will also become mentally disordered. This ensures work for future generations of mental health professionals.

8. Bouncing
Some cases of mental disorder are so serious that they have to be bussed off to a hospital. Unfortunately, they become lost to corrections, at least temporarily. They go out as schizophrenic and they come back as "personality disordered."[16] The only bright side is that, without medication and personal support, they will relapse on return. These extreme cases provide training for staff who need to improve their driving skills. Being bussed frequently from hospital to prison and from prison to hospital almost guarantees that the inmates will be overwhelmed by symptoms of mental disorder. Disorientation is a powerful device. Most of us get sick when we do not know where we are. Once in a while, some bright spark tries to put forward the idea that there should be co-operation and co-ordination among ministries and departments (e.g., Justice, Solicitor General, Health and Welfare, Housing). However, there is little fear of such developments as the careers of most senior administrators are fortunately tied to advancement within their own ministry. Of even less moment are those who waste their days seeking improved connections between federal and provincial agencies.

9. Unaccountability
It is a big mistake to attempt any systematic evaluation of remedial projects. Would-be researchers should be eased out promptly with the appropriate degree of politeness. Otherwise, these people might demonstrate that the program is effective, and the workload would thus increase dramatically. While this outcome may be positive over the long run, in that the project will likely collapse under the weight of many inappropriate new referrals, it will take time. On the other hand, the evaluators may demonstrate that the program is ineffective. While this finding is good because ineffective programs actually induce mental disorder, it means looking for another job. Either way, program evaluation is for losers. The best approach, as suggested in section 6 above, is to adopt some apparently simple technique (e.g., pink walls, megavitamins, or pet therapy) and scrupulously avoid any attempt at evaluation (i.e., do not ask inmates for opinions, avoid checks on recidivism, etc.).

10. Uninvitingness
It has already been suggested that mental health professionals play a positive role by unwittingly increasing the overall level of mental disturbance. They can, for example, perceive a disorder that does not exist (section 3) or undertake program development in naïve ways (section 6). Yet, as previously noted, these individuals need to be watched. Some have the misguided idea that Martinson was wrong (section 5), and the unfettered use of doctors and their medicines is undesirable (section 2). Correctional services do not need too many of these social workers, psychologists, and psychiatrists (though, truth to tell, many are quaint, and their eccentricities and excesses would be missed). Certainly, it is a mistake to let them

[13] *Megargee, E. (1982). "Reflections on Psychology in the Criminal Justice System," in* Abnormal Offenders, Delinquency and the Criminal Justice System. *London: Wiley.*

[14] *Erickson, R., Crow, W., Zurcher, L., & Connett, A. (1973).* Paroled but Not Free: Ex-Offenders Look at What They Need to Make It Outside. *New York: Behavioral Publications.*

[15] *Correctional Service of Canada (1989). "Review of Treatment Research Within the Regional Psychiatric Centres and Pinel Institute,"* Forum on Corrections Research *1, no. 1, 20-22.*

[16] *Toch, H. (1982). "The Disturbed Disruptive Inmate: Where Does the Bus Stop?"* The Journal of Psychiatry and Law *10, 327-349.*

become too comfortable.

Doctors can be kept in place by edicts designed to limit the scope of their practice. Such "guidelines" should change frequently, and their actual source should be unclear. Every time a parolee violently reoffends, a dozen psychologists should be diverted instantly from program development and evaluation to "dangerousness assessments" (or rather "risk assessments"). They will be confined to their offices, ever more isolated from life in the institution or community housing project. They will also become bored, especially if the assessments are not conducted within the context of some research plan to which they are contributing. Other indignities can be heaped on them. For instance, they could be allowed to start a project, maybe even with allocated space and resources. Once the program is operating, it must be stopped suddenly, on the flimsiest grounds possible. Another good idea is to block a staff member from giving a paper at a conference, purportedly because the material is too contentious or is against policy. Creativity must be stopped, unorthodoxy eliminated. Astute readers may see that, as mental health workers themselves are not immune to psychiatric disorders, many of the principles outlined here can be turned against would-be helpers. With a little planning, it should be possible to raise the incidence of mental disorder not just within the inmate population, but among the mental health staff as well.

How to Develop a Model for the Effective Treatment and Care of Mentally Ill Prisoners

It is not that we lack the information or even the professional assistance to treat mentally disordered offenders. But, at this point in Canada, we are only just beginning to develop the necessary outlook within federal corrections. The Mission Statement will help, as it generally addresses the issues raised in this article. Now, however, these principles need to be developed, especially as they apply to mentally disordered offenders. The Task Force will also help. So might consideration of the points sketched above. The argument is that mental disorder in the Correctional Service of Canada could be substantially *reduced* by: (1) diverting at the outset cases that, by any reasonable standard, should fall within the scope of the health authorities; (2) ensuring that mentally disordered offenders remain connected to a wide range of services within the institution and beyond; (3) becoming more fully aware of the possible iatrogenic effects of psychiatric and psychological assessments; (4) ensuring that routine psychological tests are properly administered and scored and that new instruments are to the point and consistent with scientific standards; (5) selecting and training staff on the basis of ability to lead and monitor remedial programs; (6) recognizing that inmates themselves have valid ideas about the programs they want and that projects must be worked out in partnership; (7) planning with individuals over the long term for integrated and manageable steps between programs; (8) developing correctional system resources to enable the full and responsible care of seriously mentally ill patients; (9) establishing effective ways to determine which programs work better than others for particular types of mentally ill prisoners; and (10) ensuring that mental health workers are allowed to play an integral role in institutional operations and planning. ■

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The Management Focus section of this issue is devoted to the activities of the Regional Psychiatric Centres (Prairies and Pacific), the Regional Treatment Centre (Ontario) and Dorchester Penitentiary. As the Correctional Service of Canada recognizes the extreme importance of these centres in the treatment of mentally disordered offenders, we are pleased to present some of the operations, developments and recent innovations of these facilities. The relevant managers of each centre have prepared the following summaries.

Dorchester Penitentiary

After over one hundred years of service as a maximum security institution, the venerable old Dorchester Penitentiary is taking on a new look for the 1990s, thanks to a major redevelopment program currently under way. Dorchester has evolved into a multilevel, multipurpose institution with an offender population of approximately 253.

A study conducted by Chefurka and Associates has been approved for guiding program direction at Dorchester Penitentiary, which includes the services of a developing Regional Treatment Centre. By 1993, the Regional Treatment Centre will consist of a 50-bed psychiatric unit, which will operate an assessment program, an acute psychiatric care unit, a chronic care unit and a transitional care section. Assessment and treatment of mentally ill offenders will be part of the centre's mandate.

Dorchester's main orientation will be to deliver several intensive therapeutic programs to offenders with addictions, learning disabilities and mental disorders, sex offenders, and inmates with anger management problems. The integrated, multidisciplinary model of the Regional Treatment Centre will target the general institutional population and thus offer management advantages in efficiency and cost effectiveness (sharing of staff, services, program facilities, etc.).

The intensive programming will allow more cases to be treated as outpatients while remaining within the prison population. The psychiatric unit role will be limited to the diagnosis and treatment of mentally ill offenders.

The Dorchester organization is a three-pronged model comprising the Correctional Operations Division, Treatment and Programs Division (which includes the Treatment Centre) and Management Services Division, reporting to the Warden. Within Dorchester, the Unit Management model will operate with three units, one of which will be the Psychiatric Treatment Centre.

The Treatment Centre currently operates at a 20-bed capacity with a 37-member staff, composed of 11 correctional officers, 18 nurses, 3 part-time psychiatrists and 5 psychologists (2 of whom are part-time), who service the whole population of Dorchester Penitentiary. All institutional programs are now directed by the Treatment and Programs Division.

A current priority is the development, by the psychologists, of a comprehensive sex offender treatment program (beginning September 1990) to complement other programs in the Region. Dorchester Penitentiary is becoming fully equipped to meet the serious challenges that the Atlantic Region faces in dealing effectively with the needs of special categories of offenders in the 1990s. The developments in Dorchester and its Psychiatric Treatment Centre will play a pivotal role in promoting activities to enhance mental health and prevent mental disorder.

These activities will ultimately result in a substantial increase in the services available to incarcerated offenders in these special categories.

Regional Treatment Centre (Ontario)

Located in Kingston Penitentiary, the Regional Treatment Centre (Ontario) is a 90-bed mental health facility under Schedule I of the Mental Health Act of Ontario. There are managers of nursing (with a staff of 51), psychiatry (4), psychology (13), adjunct therapy (11), and security (31).

The following programs are offered:

1. Sex Offender Program
With 25 in-patients, the 18- to 20-week program consists of assessment, group therapy and individual counselling. The approach is cognitive-behavioural therapy.

An out-patient sexual offender program is provided at Kingston Penitentiary. Focusing on long-term offenders, the 16-week program uses cognitive-behavioural therapy.

2. Female Unit
The program provides assessment and treatment for up to 10 patients from the Prison for Women for an average of four months. The focus is on behaviourial adjustment.

3. Acute Psychiatric Unit
The program provides medication and psychotherapy for up to 16 patients. The focus is on stabilizing psychotic episodes and monitoring suicidal inmates in order to permit return to the institution or entry to another Regional Treatment Centre program. The average stay is two months. On a long-term basis, the unit also manages a few mental disorder cases with continuing risk of violence.

4. Subacute and Assessment Unit
This program provides psychiatric assessment and treatment of subacute mental disorders for up to 16 patients.

5. Rehabilitation Unit
The program provides maintenance and skill development for up to 16 patients. The average stay is 180 to

365 days. However, there is a bimodal distribution of shorter-term cases, who are discharged to other institutions at an improved level of functioning, and long-term cases, who are unable to function in a normal prison.

6. Adjunct Therapies
Provided by a central group to all programs, these include occupational therapy, recreation, education, leisure activities, life skills, Alcoholics Anonymous, case management and problem solving.

7. Ambulatory Care
This program provides psychiatric services (assessment, medication and psychotherapy) to other institutions, psychiatric nursing follow-up to discharged patients in other institutions, and community liaison for released patients.

Research and Evaluation
In the past year, Regional Treatment Centre staff presented five papers at two conferences. Topics included empathy training for sex offenders, recidivism studies and medication treatment of aggression. There is no formal research position. The future role of research and program evaluation is currently under review.

Breakdown of Discharges by Diagnosis (April 1989 to March 1990)

Diagnosis	# of discharges		Average length of stay in days
Psychosis	68	(19%)	113
Neurosis	4	(1%)	90
Personality disorder	51	(15%)	109
Other mental disorder	43	(12%)	51
Alcohol/Drug abuse	9	(4%)	79
Sexual deviation	158	(46%)	51
No psychiatric diagnosis	5	(1.5%)	22
Malingering	5	(1.5%)	6
Total	343	(100%)	

Regional Psychiatric Centre (Prairies)

The Regional Psychiatric Centre (Prairies) is operated by the Correctional Service of Canada in affiliation with the University of Saskatchewan. Built on land owned by the university, the centre is the result of co-operative planning between the Province of Saskatchewan, the University of Saskatchewan, and the Government of Canada. Designated as an "in-patient" facility under the Saskatchewan Mental Health Services Act, the centre provides assessment and treatment programs for:

a) inmates of the Correctional Service of Canada, primarily from the Prairies Region;
b) inmates from the correctional system of the province of Saskatchewan;
c) individuals remanded by the courts of Saskatchewan; and
d) individuals in confinement under Warrants of the Lieutenant Governor of Saskatchewan.

The centre has achieved and maintained accreditation from the Canadian Council on Health Facilities Accreditation since October 1984.

A unique feature of the centre is its solid partnership with the University of Saskatchewan. The affiliation agreement emphasizes the importance of the centre's major teaching and research role and provides for senior professional staff to hold joint faculty appointments with the university. The agreement also provides for a board of governors, with university and community representation, to provide overall direction and guidance for the centre. Over the past year, the board updated the centre's Mission Statement to ensure its compatibility with the Mission of the Correctional Service of Canada. On February 23, 1990, the new Mission Statement was approved by the board of governors and endorsed by the Commissioner:

> The mission of the Regional Psychiatric Centre (Prairies) is to provide clinical assessment and treatment services for mentally disordered individuals referred within the Criminal Justice System and to assist them in optimizing their mental health; to provide learning opportunities for students, the public, and personnel associated with the health care and criminal justice systems; and to facilitate, promote and conduct research in the area of understanding criminal behaviour, the administration of forensic mental health services, treatment of individuals who come into conflict with the law, and the impact of crime on society.

The Centre has 106 beds, divided into five units:

a) Assiniboine Unit does admissions and assessments. The courts of Saskatchewan, the National Parole Board and correctional administrators refer individuals for comprehensive assessments to aid in decision making and to determine treatment needs.
b) Churchill Unit provides treatment services for acutely mentally ill patients.
c) Clearwater Unit provides programs to meet the needs of patients who have problems with sexual adjustment.
d) Bow Unit treats individuals suffering from chronic mental illnesses.
e) McKenzie Unit provides a program based on the therapeutic community model and admits patients diagnosed as personality disordered, antisocial type.

In addition to the core unit programs, the centre offers a wide range of programs outside the units: substance abuse therapy, occupational therapy, recreational therapy, education, and spiritual services.

The centre's research program has received increasing emphasis and involves collaboration with the academic community and the Correctional Service of Canada. Studies have been undertaken in six primary areas:

a) The Sexual Offender
b) The Aggressive Inmate
c) The Criminal Psychopath
d) The Native Offender
e) Substance Abuse and Criminality
f) General Forensic Issues

The Regional Psychiatric Centre (Prairies) is meeting a major need of the Correctional Service of Canada and the province of Saskatchewan. In 1989, 329 patients were admitted — 98 for assessment and 231 for treatment. Average daily occupancy during 1989 was 98.42, which consisted of an average of 83 federal offenders and 15 in the provincial categories (including remands and Lieutenant Governor Warrants).

Regional Psychiatric Centre (Pacific)

Regional Psychiatric Centre (Pacific) was originally opened as a drug treatment centre for female inmates in 1966. In 1972, the facility was converted to a male psychiatric centre. It shares a penitentiary reserve with Matsqui Institution, Sumas Centre and the Materiel Management Centre. RPC (Pacific) is a multilevel facility and now offers a day parole program.

RPC (Pacific) functions as a psychiatric hospital under the British Columbia Hospital Act and is regulated by the British Columbia Mental Health Act. It is accredited by the Canadian Council on Health Facilities Accreditation.

The centre provides for the mental health needs of incarcerated inmates in the Pacific Region, referrals from other Correctional Service of Canada regions, and Order-in-Council patients.

Management Model

The responsibility for the operation of the RPC (Pacific) rests with the Executive Director, who reports to the Deputy Commissioner, Pacific Region. Reporting to the Executive Director are three divisional heads: the Director of Treatment Services, Director of Nursing Services and Director of Operations Services.

Staff Complement

As of March 31, 1990, the staff complement was 193.5 person-years. The person-year base of 193.5 includes 12 person-years for the Regional Hospital Escort Team.

Rated Capacity

Psychiatric beds	146
Segregation beds	4
Total	150

Relationship With Other Facilities

RPC (Pacific) provides an ambulatory service at all Pacific Region institutions for assessment, local intervention, and follow-up care, as well as after-care treatment services until warrant expiry for offenders released in the Pacific Region.

Inmate Profile

As of March 31, 1990, approximately 60% of the inmate population were serving their first term of federal incarceration. While the most common age group (25-29 years) is consistent with the rest of the region, RPC (Pacific) is unusual in that its most common sentence is a life sentence (29.5% of its population). The most common crimes for which offenders are incarcerated at RPC (Pacific) are sexual offences (26.6%) and murder (14%).

Inmates admitted to RPC (Pacific) suffer from a variety of mental health disorders, at different levels of severity. The patient population comprises several diagnostic groups, and their distribution is limited to the ward space available:

	No. of beds available
Acute and chronic psychotic patients	26
Inadequate/marginal social development patients	30
Personality disorder — antisocial patients	30
Personality disorder — sex-offender patients	30
Assessment admissions/parole, prerelease, day parole	30
Total	146

Core Program

As RPC (Pacific) is primarily an assessment and treatment facility, core programs and activities are treatment-focused. The centre provides a full range of library services, educational programs, life skills, and substance abuse programs.

Core Activities

The Chief of Occupational and Adjunctive Therapies is responsible for the development and delivery of core activities, which include arts and crafts, visits and correspondence, private family visits, art therapy, recreation, horticulture, and work placement.

Like the core programs, core activities are expected to contribute to the treatment of patients, whose involvement, placement and progress are reported to and shared with the multidisciplinary team.

Inmate Development

As the main focus at RPC (Pacific) is treatment, no patients are employed at full day jobs. Patients are paid at various rates for participation in authorized work and treatment placements. The distribution and deployment of inmates in the various placements is reviewed and evaluated by the multidisciplinary team to ensure that all programs supplement and reinforce the patients' treatment plan.

All patients are expected to occupy their time with treatment, and a "job" may be an adjunct to therapy. A patient's allowance is based on degree of participation in the treatment program and ability to handle work responsibilities.

Admission/Discharge and Treatment Activities

Between 1984 and 1990, RPC (Pacific) admitted and discharged 180 to 195 patients per year. Historically, one third of patients are discharged within six months of admission; one third are discharged after 6 to 12 months of treatment; and another one third remain in treatment for 12 to 24 months. Most of the long-stay patients are those with a primary diagnosis of serious mental disorder (schizophrenia, manic depression) or borderline retardation.

Research and Program Evaluation Activities

The members of the multidisciplinary treatment team (psychiatrists, psychologists and nurses) are very interested in thoroughly evaluating their programs and following up their patients after treatment. The ambulatory services department and other professional staff will actively participate in research and evaluation projects during 1990-91. ■

Release of Inmate Psychiatric Information

by Karen J. Richardson, Legal Counsel
Legal Services, Correctional Service of Canada

In keeping with the mental health care theme in this issue of FORUM, Legal Services examines some of the complex issues surrounding the release of inmate psychiatric information.[1] However, the following represents only a general discussion of these issues, and Legal Services should be consulted in cases involving any uncertainty. Readers are also reminded that health care legislation often varies between provinces and this may affect decisions regarding the release of information.

A. Background: Duty of Confidentiality

The duty of a physician to maintain patient confidentiality is *not* absolute, as enunciated in the Canadian Medical Association's Code of Ethics:

> An ethical physician will keep in confidence information derived from his patient, or from a colleague, regarding a patient and divulge it only with the permission of the patient except *where the law requires him [or her] to do so.* (emphasis added)

There are several reasons why physicians and hospitals desire control over patient records. The records usually contain medical language not readily understandable by a non-medically trained person. Moreover, revealing certain information (for example, about a terminal illness or suicidal tendencies) could be detrimental to the patient's health and future treatment; this is especially true of psychiatric information. The records may also contain references to other persons that should not be disclosed to the patient. The premise behind all these reasons is the belief that the physician is in the best position to judge what information should be disclosed.

Courts have held that doctors must not volunteer patient information without the consent of the patient unless they are required to do so by due process of law.[2] The Correctional Service of Canada is in a unique position because requests to release medical information are often linked to judicial or administrative proceedings before a court or a parole board. In such cases, the duty of confidentiality, which requires openness and honesty between patient and physician, must be balanced against the public interest in the administration of justice.

B. Release of Information to Inmate

Offenders have the same legal rights as members of the general public to the confidentiality of information obtained by a health care professional and to access to that information. The policy of the Correctional Service of Canada on the release of inmates' medical reports is that, except for subpoenaed records, no confidential medical information shall be released from the control of health care staff or divulged to unauthorized persons.[3]

Inmates are normally allowed access to their own medical files; however, several circumstances would preclude automatic release: for example, if the file contained information about a third party,[4] if the information could seriously interfere with the inmate's institutional community program,[5] or if it could cause harm to another person.[6] Access could also be denied if the physician believed that the information might be harmful to the patient[7]; however, the doctor may have to provide compelling evidence to support that position. In *Lindsay v. D.M.*, the court allowed a former mental hospital patient the right to access his medical records, although this right had previously been denied; the onus was put on the hospital to justify why such disclosure should not ensue.[8]

If the Correctional Service of Canada determined that one of the above circumstances for denying access existed, the inmate could apply for a reconsideration of the request under the *Privacy Act*. If the Privacy Commissioner again denied access, the inmate could then apply to the Federal Court for a review of the decision and a determination of whether or not the decision has been fairly reached.[9]

[1] *Rules pertaining to medical documents apply to institutions, physicians and any other persons who compile them. No distinction is made between physicians' reports, nursing reports, psychological reports, etc. Thus, any record originating from a health care professional is governed by the rules of confidentiality as discussed in this article. These rules do not apply, however, to information in psychological reports prepared for non-medical purposes.*

[2] Canada (Solicitor-General) v. Ontario (Royal Commission of Inquiry into the Confidentiality of Health Records) *(1979), 47 C.C.C. (2d) 465 (Ont. C.A.). The Supreme Court of Canada overturned the Court of Appeal decision; however, Chief Justice Laskin quoted this duty with approval in his dissent.*

[3] *Correctional Service of Canada, Medical and Health Care Services. Policy No. 105.1; Commissioner's Directive No. 835.*

[4] Privacy Act, *R.S.C. 1985, c. P-21, s.26.*

[5] *Ibid., s.24(a).*

[6] *Ibid., s.25.*

[7] *Ibid., s.28.*

[8] *[1981] 3 W.W.R. 703 (Alta. C.A.).*

[9] Access to Information Act, *R.S.C. 1985, c. A-1, ss. 44 ff.;* Federal Court Act, *R.S., c.10 (2d Supp.), s.18.*

C. Release of Information to Persons Other than the Inmate

In the absence of a court order, the Correctional Service of Canada is under no obligation to release medical reports to the inmate's lawyers or other persons, even with the consent of the inmate. However, release could be acceptable in some circumstances, such as in cases where the inmate has already reviewed the information, is fully aware of their contents and has consented (preferably in writing) to their release. Again, it is important to ensure that any released information does not contain references to "personal information" about other persons, as such information is protected under the provisions of the *Privacy Act*. If the Correctional Service of Canada refuses access, the inmate is still free to make an application under the *Privacy Act* to obtain the document and may later forward the document to other persons.

Thus, in the release of medical information to persons other than the inmate, even with the inmate's consent, it is important to remember that disclosure of medical records requires the patient's written consent or a court order.

D. Release of Information for Parole Hearings or Detention Reviews

The release of medical information without the patient's consent is generally contrary to all established principles of privacy and confidentiality. Notwithstanding this general principle, this area has been the subject of much discussion within the Correctional Service of Canada. Given the nature of some offenders' psychiatric profiles and potential behaviour upon release into the community, it is readily understood that certain psychiatric information would be crucial to any discharge decision. Once again, the individual's right to privacy and confidentiality must be weighed against the public interest in safety and the administration of justice.

The *Parole Act* states that when the Correctional Service is of the opinion that an inmate meets the criteria for detention, it shall refer the case to the Parole Board, together with all information that is relevant to the case.[10] For a parole hearing, the Board will consider all relevant information in the review of the case.[11] The need to balance individual privacy with the public interest may provoke a jurisdictional conflict, as health care is a provincial matter and parole is a federal matter. This jurisdictional conflict may be exacerbated by the fact that the federal Regional Treatment Centre and Regional Psychiatric Centres fall under federal jurisdiction and under the applicable provincial Mental Health Acts. Therefore, there may be a conflict between provincial and federal laws, which will have to be resolved on a case by case basis.

The jurisdictional problems were well illustrated in the case of *R. v. Worth*,[12] in which medical records were sought to corroborate evidence that a man convicted of first-degree murder had, just prior to his release from penitentiary, told his case management officer he would kill again. A search-and-seizure warrant was issued under the *Criminal Code of Canada* to obtain his records from the Regional Psychiatric Centres Prairies and Pacific, where he had been treated. As the court pointed out, Ontario's and Newfoundland's statutory provisions outlined the procedure for obtaining medical records and protecting their use, but there was no parallel provision in the Saskatchewan or British Columbia health acts. Moreover, British Columbia had no guidance for determining the circumstances in which medical records could be released. Thus, the court relied solely on the *Criminal Code* provisions (with no assistance from the provincial statutes) in reaching its decision to uphold the warrant, although there may have been a different outcome had the accused been treated in Ontario or Newfoundland.

E. Inmate's Access to Reports Once Released to Review Board

Principles of natural justice require that a person know the facts of any case against him or her in order that a full and proper defence or response can be prepared. Given the delicate nature of the subject matter and the often controversial conclusions in psychiatric reports, it could be psychologically detrimental for an inmate to read the comments of a treating physician. In parole and detention hearings, the court, in compliance with its duty to act fairly, continuously weighs the privacy rights of the individual against the health and welfare of the individual and society.

In a recent New Brunswick Court of Appeal case, *McInerney v. MacDonald*,[13] the court found that a contractual relationship existed between doctor and patient, and that the patient was entitled to have access to all the information contained in the medical report. This supported the earlier Ontario decision, *Re Abel & Penetanguishene Mental Health Centre*,[14] in which the court held that the Chair of the Review Board had the authority to disclose information placed before the Board to the patient.

However, if disclosure of certain information could result in harm to the health of the inmate, the physician could request that such information not be released to the inmate.[15] In *Re Egglestone & Advisory Review Bd.*, the court found that it was appropriate for the Review Board to allow counsel access to the clinical record on the condition that the information in the

[10] *R.S.C. 1985, c. P-2, s. 21.3(2).*
[11] Parole Regulations, *s. 17.*
[12] *(1989), 54 C.C.C. (3d) 215 (Ont. H.C.J.).*
[13] *(1990), 66 D.L.R. (4th) 736*
[14] *(1979), 97 D.L.R. (3d) 304 (Ont. H.C.); affirmed 119 D.L.R. (3d) 101 (Ont. C.A.).*
[15] Parole Regulations, *s. 17(5).*

record not be disclosed to the client.[16] In *Re Stumbillich & Health Disciplines Bd.*, it was further determined that to comply with the principles of fairness, it was not sufficient to provide summaries of documents supporting a complaint committee decision; rather, the documentation itself must be provided to the individual.[17]

F. Conclusions

Subject to certain exceptions, all Canadian citizens and permanent residents have the right to access information contained in their psychiatric records; inmates also have this inherent right. The Correctional Service of Canada has the final authority to determine whether or not psychiatric reports should be released upon request, but given the complicated nature of the exceptions listed above, it is usually wise to have the inmate gain access under the *Privacy Act*.

Treating physicians and health care officials have a professional duty to maintain the confidentiality of inmates' medical records and protect against the unauthorized release of psychiatric information. However, this right to individual privacy must sometimes be balanced against the public interest in safety and the administration of justice.

An inmate's psychiatric information is often pertinent to parole hearings and detention reviews; the *Parole Act* allows for submission of any information relevant to the case, including sensitive medical information. Again, individual rights are weighed against societal rights in the determination of informed parole and detention decisions. A case-by-case analysis is necessary, given the nature of the medical information involved and the vast differences between applicable provincial mental health legislation. ■

[16] *(1983), 150 D.L.R. (3d) 86 (Ont. Div. Ct.).*

[17] *(1984), 12 D.L.R. (4th) 156; affirmed 3 D.L.R. (4th) 416 (Ont. C.A.).*

The following summaries or extracts from reports, opinions and other documents are provided for the information and convenience of the reader. However, as the extracts are not complete, the reader should refer to the actual opinion or document or consult with Legal Services at National Headquarters concerning the specific interpretation or applicability of any opinion or decision cited. If you have any questions about these or any other related matters, please contact Theodore Tax, Senior Counsel, Department of Justice, Legal Services, Correctional Service of Canada, National Headquarters, 4A-340 Laurier Ave. West, Ottawa, Ontario K1A 0P9.

RECENT DECISIONS

In *Cleary v. Correctional Service of Canada & National Parole Board*, Mr. Cleary was scheduled for a detention hearing before the Board. The *Parole Regulations* stipulate that the Board provide the inmate with a written summary of the relevant information in its possession at least 15 days before the date of the hearing. Because of a strike involving Correctional Service of Canada employees, the material was delivered only nine days before the hearing. Mr. Cleary applied to the Federal Court (Trial Division) for an Order quashing the National Parole Board's decision, but the Court dismissed his application on the grounds that the provisions regarding time frames were directory, not mandatory, and that the Board had acted within its authority. In April 1990, an appeal by Mr. Cleary to the Federal Court of Appeal was also dismissed, but the Court said that the time frames were in fact *imperative*. The Court of Appeal held that the trial judge had a discretion to grant the relief requested, and as Mr. Cleary had suffered no prejudice, the Court should have used its discretionary power to deny Mr. Cleary's application.

On May 31, 1990, the Federal Court of Appeal delivered its decision in *The Commissioner of Correctional Service of Canada v. Veysey*. Inmate Veysey had been refused the possibility of a private family visit with his partner of the same sex. The Court provided a legal interpretation of paragraph 19 of the Commissioner's Directive number 770 on Visiting, which establishes a list of eligible visitors. In combining the expressions "common law partners" and "relatives" and in looking at the purpose of the program, the Court concluded that the Commissioner could have exercised his discretion and granted the visit with the same-sex partner. While the Court did not determine the case by applying section 15 (Equality Rights) of the *Canadian Charter of Rights and Freedoms*, it did acknowledge the Attorney General of Canada's position that sexual orientation was a ground for discrimination under section 15 of the *Charter*. The Court refrained from deciding whether same sex partners could be considered common law spouses. ■

In Canada today, as in other parts of the world, mental health care in correctional settings is receiving increased attention. Below is an overview of some European practices in this field.

The discussion focuses on aspects of mental health care in the prison systems of France, Switzerland and Scandinavian countries. In his article entitled "Problèmes quotidiens de psychiatrie pénitentiaire à travers les changements du paysage psychiatrique et pénitentiaire de la France" (Daily problems of prison psychiatry in the light of psychiatric and prison changes in France), Pierre Lamothe gives a brief background of the treatment of mentally ill inmates. The study by Marie-Jeanne de Montmollin, "La prise en charge des délinquants mentalement anormaux dans le cadre du concordat sur l'exécution des peines et mesures entre les cantons romands (Suisse)" (The care of mentally ill offenders under the agreement among the French-speaking Swiss cantons on the serving of sentences), describes the operation of a psychiatric institution serving this population. Finally, Georg Hoyer's article "Management of Mentally Ill Offenders in Scandinavia" discusses ways of managing two types of mentally ill inmates.

Mental Health Care in Correctional Settings in European Countries: France, Switzerland and Scandinavian Countries

FRANCE

The article by Pierre Lamothe, a psychiatrist with legal expertise, discusses the reorganization of psychiatric services that has occurred in French penal institutions in recent decades. The government has had to change its health services as a result of fewer psychiatric hospitalizations and an increasing number of offences by mentally ill persons.

Before 1977, most prisoners requiring psychiatric services were incarcerated in *maisons d'arrêt* with offenders who did not require mental health services. These *maisons d'arrêt* generally housed persons awaiting trial, drug addicts, juvenile delinquents, and offenders serving short sentences. Offenders serving long sentences were incarcerated in central maximum security prisons or medium security correctional centres.

In 1977, the first of 17 *centres médico-psychologiques régionaux* — CMPR — (regional medical-psychological centres) was built as an annex to one of the larger *maisons d'arrêt*. The name of the *centres* was legally changed to *Services médico-psychologiques régionaux* (SMPR) in 1986. However, the original name (CMPR) is retained in this article.

Now, when offenders are admitted to a CMPR, the psychiatrists introduce them to quasi-traditional therapeutic techniques that will teach them how to help themselves — for example, visualization therapy, interpretive psychotherapy, support therapy, and individual or group relaxation.

A new technique that has emerged in recent years uses the body as a means of expression. A biofeedback therapist shows the patient how the body can be used in non-aggressive and respectful ways when interacting with others.

According to the author, the medical-psychological centres have allowed the French prison system to respond more effectively to the special needs of mentally ill inmates.

Lamothe, P. (1988). "Problèmes quotidiens de psychiatrie pénitentiaire à travers les changements du paysage psychiatrique et pénitentiaire de la France," *Criminologie* XXI, no.2, 63-81.

SWITZERLAND

The agreement on prison sentences that was concluded in 1969 among 26 Swiss cantons provided for the establishment of special institutions for mentally ill patients. As a result of this agreement, the Centre de sociothérapie pénitentiaire La Pâquerette and the Quartier carcéral psychiatrique (QCP) were built to house this special-needs population.

Marie-Jeanne de Montmollin, of the Institut de médecine légale in Geneva, examines both of these establishments in her article. However, as the QCP opened only in 1988 and houses a maximum of seven patients on a short-term basis, the present article focuses on the operation of the La Pâquerette facility.

When it first opened in 1979, the La Pâquerette centre operated as a sociotherapeutic day clinic for offenders who had problems functioning in the regular inmate population of the Geneva prison. In 1986, the La Pâquerette centre increased its program capacity to allow more inmates to participate. Inmates can now stay at the facility, rather than visit on a daily basis to attend the program.

In order to be admitted to the program, inmates must apply to the management of the centre and of the prison where they are incarcerated. The La Pâquerette centre accepts only inmates who are suffering from severe personality disorders with sociopathic traits, as defined in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM III).

The majority of the patients treated at the centre are impulsive, are violent repeat offenders, display sexual deviance, anxiety and depression, and feel they have not accomplished anything in life. The major crimes of inmates who have stayed at the centre for more than four months since its opening have been murder, attempted murder, serious bodily injury, sex offences, arson, robbery, property offences and drug offences.

The main objective of the program is to teach offenders to take responsibility for themselves. The first

step is to require the inmates to make a commitment to the program. They must sign a renewable four-month contract committing them to active and positive participation in the centre's activities and to good conduct. Inmates can be expelled from the program for committing a serious infraction. For less serious infractions, inmates may be barred from certain daily activities.

Patients are encouraged to participate in discussions, listen to others and talk about themselves in order to learn to express their feelings and emotions and relate to others in non-violent ways.

Therapists, inmates and other staff members attend general meetings three times a week to discuss and address problems related to community life. Decisions on the centre's internal operation are arrived at by a majority vote. Other, more structured meetings, held twice a week, are designed as a forum for patients to discuss their personal problems with therapists. Treatment also takes the form of general activities (crafts, sports, religious services, etc.).

A great deal of emphasis is placed on the social reintegration of the offender. After patients have successfully completed the program, they are introduced to other activities that are more specifically designed to familiarize them with the realities of daily life in the community. Rather than being released immediately into the community, patients are prepared gradually for reintegration. They are sent on escorted outings and are taught the basics of life on the outside. The reintegration process is very similar to psycho-social programs offered in Canada.

Between August 1, 1979, and April 30, 1988, 123 inmates participated in the program; of that number, 23 did not complete the program — 10 quit and 13 were expelled. Of the 55 offenders who completed the program after a stay of longer than four months, 20 were convicted again within two years of their release, 19 disappeared, and 16 had not recidivated at the time this data was collected.

De Montmollin, M.-J. (1989). "La prise en charge des délinquants mentalement anormaux dans le cadre du concordat sur l'exécution des peines et mesures entre les cantons romands (Suisse)," *Revue internationale de criminologie et de police technique*, March, 308-329.

SCANDINAVIAN COUNTRIES

It is well known that, compared with the Western world, the Scandinavian countries have very low rates of incarceration, especially for serious offences, such as robbery and assault. The management of mentally ill offenders in these countries is also unique.

Although each monarchy has its own penal code and legal process, there are similar approaches in dealing with mentally ill offenders.

A common principle in Scandinavian penal codes is that persons found to be not responsible for their behaviour cannot be punished. There is no consensus, however, on the criteria for identifying criminal responsibility and classifying people as insane or severely mentally deficient. In Denmark and Sweden, for instance, the ability of offenders to understand the implications of their conduct is a criterion for criminal responsibility, whereas in Norway, this is not a criterion. Although sanctions can be omitted for these offenders, special sanctions are applied in most cases.

When mentally ill offenders are found not liable for punishment, they can be sanctioned to preventive detention institutions, which are part of the prison system and run by the department of justice. In 1989, the prison system in Norway provided 133 preventive detention beds, some of which were occupied by general population prisoners. Sweden and Denmark, on the other hand, did not provide this type of accommodation.

In the same year, beds in psychiatric units accommodated 139, 22 and 65 mentally ill offenders in Denmark, Norway and Sweden, respectively. Mentally ill offenders found not liable for punishment can also be committed to psychiatric institutions run by the health authorities as part of the regular mental health services delivery system. The mental health care system provided special maximum security psychiatric wards of 25, 15 and 373 beds for the respective countries.

As Professor Georg Hoyer indicates, mentally ill offenders found not liable for punishment are usually ordered to an initial maximum length of confinement. This order can be renewed an unlimited number of times if the authorities deem it necessary. A potential drawback noted by Hoyer is that the offenders may spend more time in confinement than if they were sentenced to regular incarceration.

Mentally ill offenders who are found liable for punishment are treated by health services established within the prison and under prison administration. According to Hoyer, these offenders are often left with other inmates who object to their presence and staff who are not qualified to deal with their acute problems.

If not placed with other inmates, mentally ill offenders found liable for punishment may be referred by the courts to involuntary treatment programs. In Denmark and Sweden, mentally ill offenders undergo treatment within the mental health services, whereas in Norway they spend their treatment time within the prison system.

Mentally ill offenders who are referred to these involuntary treatments often suffer from behavioural disturbances such as psychopathic disorders and borderline states, substance abuse and mild mental disorders. In Sweden and Denmark, involuntary treatment can be applied instead of punishment or in addition to it, as it is in Norway.

There is an ongoing debate in Scandinavia about whether the small number of mentally ill offenders found liable for punishment should

be referred to regular mental health services because they suffer from medical problems. Courts and prison administrations argue that public mental institutions cannot provide the level of custodial security required to care for mentally ill offenders. Revision of the Scandinavian penal codes, currently under way, will focus on the transfer of management of mentally ill offenders.

Professor Hoyer points out that Scandinavian and Western countries face similar problems in the management of mentally ill offenders.

Hoyer, G. (1988). "Management of Mentally Ill Offenders in Scandinavia," *International Journal of Law and Psychiatry* 11, 317-327.

The above articles seem to indicate that mental health care for mentally ill offenders is as important in European countries as it is in Canada. It is interesting to observe the similarities in the management of mentally ill inmates. Like many other countries (including Canada), France experienced a deinstitutionalization of its psychiatric hospitals in the 1970s. In 1977, the French Government made sweeping changes in health care services to the country and the prison system, and made provisions for the ever-increasing number of mentally ill offenders populating the prisons.

In Switzerland, mental health care for mentally ill inmates closely resembles some of the therapeutic programs and approaches used in the Regional Psychiatric Centres of the Correctional Service of Canada.

And at first glance, Scandinavia's categorization of mentally ill offenders — those who are responsible for their actions and those who are not — resembles the Canadian model. It is interesting to see that the Scandinavians are revising their management process with respect to this clientele in order to shift the responsibility for the mental health care of offenders from the prison system to the regular health care system. ■

This section of the magazine is devoted to short summaries of selected conferences, seminars and workshops attended by Correctional Service of Canada staff in Canada or abroad. Some effort is needed on the part of all staff if we are to take seriously the importance of sharing ideas, knowledge, values and experience, nationally and internationally. We ask you to join in this effort and contribute your reflections and observations when you attend significant events as representatives of the Correctional Service of Canada.

March 1-3, 1990
CANADIAN MEDICAL ASSOCIATION (CMA) LEADERSHIP CONFERENCE
Ottawa, Ontario

The theme of the second Canadian Medical Association (CMA) Leadership Conference was "Allocation and Decision Making." Senior health care leaders (including the Director General, Health Care Services), politicians and policy makers from Canada and the United States discussed what the Canadian health care system could and should deliver, its ethical issues, and how to improve management practices.

The participating physicians were encouraged to address the public policy issues and to play a stronger leadership role in Canadian health care in this age of recurrent and greater financial constraints. Participants were reminded that the system needs to deliver access to an affordable variety of services; more community-based services; more health-promotion and disease-prevention services; and access to co-ordinated ethical care and positive work environment.

The CMA booklet *HIV Antibody Testing — Counselling Guidelines* was distributed at the conference. Copies will be forwarded to all Correctional Service of Canada health care and allied staff. The third CMA Leadership Conference will be held in Vancouver, British Columbia, in 1992.

April 25-27, 1990
THE WELL PERFORMING GOVERNMENT ORGANIZATION "CELEBRATION AND SCRUTINY" INTERNATIONAL CONFERENCE
Victoria, British Columbia

"Celebration and Scrutiny" was the first major international conference to focus entirely on excellent performance in government organizations. Conference speakers were acknowledged leaders in this emerging field and spoke from experience about managing for excellence. The Correctional Service of Canada was represented at this event by a large delegation of approximately 20 participants.

Workshops focused on ways of getting the process started, barriers that inhibit government managerial excellence, and scrutiny of key issues such as accountability, unions, employment equity, and communications. As well, the concept of building high-quality organizations was illustrated by success stories from the Canada Mortgage and Housing Corporation, Washington State Licensing Department, British Columbia Pavilion Corporation, and Client Services, City of Montréal.

The research conducted by Otto Brodtrick for the Auditor General of Canada provided an example of federal public service organizations that have achieved excellence. Examples from the federal, provincial and municipal levels, and the American and Australian systems, all focused on the absolute requirement for employees and clients to be involved in all aspects of the change process.

John Amatt, a member of the first Canadian team to climb Mount Everest, likened successful management to leaving the "beaten path" and switching to the "unbeaten path" of the 1990s. Government organizations must have a vision, the courage to take a risk, the endurance to keep going, and the teamwork to achieve excellence together.

May 7-11, 1990
ASSOCIATION OF PAROLING AUTHORITIES INTERNATIONAL (APAI) CONFERENCE
Toronto, Ontario

This year's conference of the Association of Paroling Authorities International was attended by delegates from various parts of Canada and the United States as well as participants from France, Sweden, Belgium and Trinidad. The Correctional Service of Canada was represented by participants from all five regions and from National Headquarters.

The theme of the conference was "Openness, Accountability and Professionalism." In the context of parole, openness meant ensuring that interested parties were notified that a decision would be made and communicating the final decision, rather than allowing the press and the public complete access to all proceedings. Accountability involved clearly identifying decision makers and making available for review the information on which decisions were based, rather than allowing the individual liability of decision makers for "wrong" decisions. Professionalism referred to the capability of decision makers to explain and justify their decisions, as opposed to leaving the decisions to the "pure" professionals.

Of particular interest were the differences in attitude toward parole in various American states, overseas jurisdictions (especially Sweden) and Canada. For example, Canada and the United States have become increasingly committed to the practice of assessing the risk of an offender in the community, whereas the Swedish Parole Board does not consider risk, on the grounds that it is extremely difficult to predict.

May 13-16, 1990
WESTERN JUDICIAL EDUCATION CENTRE CONFERENCE
Lake Louise, Alberta

Attended by aboriginal peoples and representatives of the various components of the criminal justice system, the Western Judicial Education Centre Conference sought to identify practical problems in the delivery of justice to aboriginal peoples. The Correctional Service of Canada was represented at the conference by Mr. Al Swaine and Ms. Lynn Daniels of the Prairies Region.

Two common themes emerged during the conference sessions: Native culture is distinct, and communication is essential to achieving understanding.

The Honourable Gerald Weiner, Minister of State for Multiculturalism and Citizenship, noted that the current crisis in the administration of justice toward native peoples could not have occurred without the legacy of decades of ambivalence and neglect toward aboriginal Canadians. As a society, we judge native people in relation to our own values, and we have thus denied their values while attempting to impose our own. Systemic discrimination is a result of identical treatment of different groups. The Supreme Court of Canada affirmed this premise in stating that *identical* treatment does not mean *equal* treatment.

A Canadian judge has introduced an innovative procedure in his courtroom to reduce the incarceration rate for native people. With the consent of the accused and on less serious charges, Judge Fred Green convenes a council of elders and postpones court proceedings until a representative of the council is available to speak to sentencing.

The Government of British Columbia has employed a creative approach toward consultation on natives in the justice system. The B.C. consultation operated on the principle that native groups could call the meetings with the consultation team, set the agenda and choose the location of the meeting. The final report concluded that measures to address the issue of native justice must be community-based, co-operative in nature, and low-key in approach. Subsequently, the British Columbia Government has pledged to participate in local justice councils and cross-cultural training, update its native people training packages, and increase native employment opportunities.

It was noted that in Manitoba, as in the rest of Canada, 45% of the native population are currently under 15 years of age, and 50% are under 18 years of age. Unless there are significant changes now in the manner in which society and the criminal justice system deal with native people, the number of those charged and incarcerated is expected to increase in the future. ■

Below is an annotated bibliography of articles on the mental health care of offenders. All the citations refer only to material published from 1988 to the present. It is hoped that the bibliography will be a valuable resource for those interested in broadening their understanding in this area.

Anyone interested in receiving copies of the articles listed may call the Research Branch at (613) 995-3340 or write to 340 Laurier Avenue West, Ottawa, Ontario, Canada K1A OP9.

Ashford, J. (1989). "Offence Comparison Between Mentally Disordered and Non-Mentally Disordered Inmates," *Canadian Journal of Criminology/Revue canadienne de criminologie* 31, no. 1, 35-47.

Comparison of offences, histories of violence and criminal histories characteristic of mentally disordered and non-mentally disordered patients in an Arizona county jail reveals that mentally disordered inmates were more likely than the average inmate to have a history of violence.

Blankstein, H. (1988). "Organizational Approaches to Improving Institutional Estimations of Dangerousness in Forensic Psychiatric Hospitals: A Dutch Perspective," *International Journal of Law and Psychiatry* 11, 341-345.

Focuses on certain organizational characteristics of the Dutch treatment setting that are essential to effective treatment and to more accurate predictions of dangerous behaviour among mentally ill patients.

Brownstone, D., & Swaminath, R. (1989). "Violent Behaviour and Psychiatric Diagnosis in Female Offenders," *Canadian Journal of Psychiatry/Revue canadienne de psychiatrie* 34, no. 3, 190-194.

Yields findings on the relationship between violent crime and particular psychiatric diagnoses. Examines age at admission with respect to type of crime committed and psychiatric diagnosis.

Coleman, C. (1988). "The Clinical Effectiveness of Correctional Staff in Prison Health Units," *Psychiatric Annals* 18, no. 12, 684-687, 691.

Suggests that while prison health units provide a natural setting for utilization of correctional staff as clinical paraprofessionals, the effectiveness of clinical intervention is often restricted because of perceived goal and role conflicts between correctional and clinical staff, and inadequate support and development for clinical training of correctional personnel.

Cox, J., McCarty, D., Landsberg, G., & Paravati, P. (1988). "A Model for Crisis Intervention Services Within Local Jails," *International Journal of Law and Psychiatry* (Special Issue: Forensic Administration) 11, no. 4, 391-407.

A description of an interagency approach to the timely identification and management of suicidal and seriously mentally ill inmates within New York State local jails. The author discusses target population and program goals; client, staff, and system goals; and administrative and service requirements.

Craig, T., McCoy, E., & Stober, W. (1988). "Mental Health Programs in Three County Jails," *Journal of Prison and Jail Health* 7, no. 1, 15-26.

Mental health programs developed in three county jails in northern New Jersey have had a number of positive results: inmates are seen and attended to quickly, acute psychotic reactions are treated, fewer inmates are sent out to local hospitals for evaluation, climate is calmer, and orderly management of the jail is facilitated.

Daniel, A., Robins, A., Reid, J., & Wifley, D. (1988). "Lifetime and Six-Month Prevalence of Psychiatric Disorders among Sentenced Female Offenders," *Bulletin of the American Academy of Psychiatry and the Law* 16, no. 4, 333-342.

Using the Diagnostic Interview Schedule (DIS version III), the study determined the six-month and lifetime prevalence of psychiatric disorders among 100 female offenders consecutively admitted to a prison. Findings showed a higher prevalence rate of schizophrenia, major depression, substance use disorder, psychosexual dysfunction and antisocial personality disorder than in the general population.

Freeman, R., & Roeash, R. (1989). "Mental Disorder and the Criminal Justice System: A Review," *International Journal of Law and Psychiatry* 12, 105-115.

Suggests that the problems of mentally ill offenders arise in part from the group's unique position at the intersection of the mental health and legal systems and that the different meanings assigned to the term "mental illness" by the two systems have led to the growth of a largely unstudied population, which falls between the two frameworks.

Germain, D. (1988). "La femme psychiatrisée en milieu carcéral," *Criminologie* 21, no. 2, 97-102.

A nurse at La Maison Tanguay, a detention centre for women in Montréal, describes the clientele of the psychiatric section, the activities and services offered to them, and her own work with inmate patients.

Greene, R. (1988). "A Comprehensive Mental Health Care System for Prison Inmates: Retrospective Look at New York's Ten Year Experience," *International Journal of Law and Psychiatry* 11, 381-389.

Describes how New York has

shifted the responsibility for prison mental health services from the state corrections agency to the state mental health agency while simultaneously experiencing a rapid and at times overwhelming growth in the prison system.

Harris, G., & Rice, M. (1988). "An Empirical Approach to Classification and Treatment for Psychiatric In-patients," *Penetanguishene Mental Health Centre Research Report* 5, no. 5, 1-28.

The study examined the incidence of 72 problems exhibited by patients in the community prior to admission or within the regional psychiatric hospital. Factor and cluster analyses were used to identify clinically important subgroups of patients.

Harris, G., Rice, M., & Cormier, C. (1989). "Violent Recidivism Among Psychopaths and Nonpsychopaths Treated in a Therapeutic Community," *Penetanguishene Mental Health Centre Research Report* 6, no. 1, 1-35.

Compares violent recidivism of 176 male psychopathic and nonpsychopathic offenders. Data suggest that after completion of two years in a therapeutic community, 40% of the total and 77% of the psychopaths recidivated after release.

Hart, S., Kropp, P., & Hare, R. (1988). "Performance of Male Psychopaths Following Conditional Release from Prison," *Journal of Consulting and Clinical Psychology* 56, no. 2, 227-232.

Administered the Psychopathy Checklist (PCL) to 231 white male criminals prior to their release from prison on parole or mandatory supervision. The PCL made a significant contribution to prediction of outcome beyond that made by other predictor variables.

Hilkey, J. (1988). "A Theoretical Model for Assessment of Delivery of Mental Health Services in the Correctional Facility," *Psychiatric Annals* 18, no. 12, 676-679.

Argues that to serve the prison population effectively, mental health workers need a conceptual framework to help define their role, the system in which they will function, and the population they will serve. The present author suggests that A. Maslow's (1970) theory of human motivation provides a viable framework for the prison environment.

Hodgins, S. (1988). "The Organization of Forensic Services in Canada," *International Journal of Law and Psychiatry* 11, 329-339.

Description of the organization and funding of mental health services in Canada for individuals accused or convicted of criminal offences. Includes presentation of mental health services for persons found incompetent to stand trial and persons found not guilty by reason of insanity.

Hodgins, S., & Côté, G. (1990). "Prevalence of Mental Disorders Among Penitentiary Inmates in Québec," *Canada's Mental Health*, March, 1-4.

With the Diagnostic Interview Schedule (DIS III-A), interviews of 650 inmates revealed that 25% suffered from major mental disorders, and 57% presented problems of drug or alcohol abuse or dependency. Only 4.7% of the inmates presented none of the disorders evaluated by the DIS.

Klassen, D., & O'Connor, W. (1988). "Crime, In-patient Admissions, and Violence Among Male Mental Patients," *International Journal of Law and Psychiatry* 11, 305-312.

Examines the relationship between hospitalizations, arrests and violence in a sample of adult male patients whose admission referral reasons suggested risk of violent behaviour.

Leroux, J., & Larivée, G. (1988). "Le rôle de l'agent de probation avec une clientèle à incidence psychiatrique," *Criminologie* 21, no. 2, 84-89.

Examines the role of the probation officer in presentence evaluation and postsentence intervention for offenders and referrals to community resources.

McMain, S., & Webster, C. (1989). "The Post-Assessment Careers of Mentally Disordered Offenders," *International Journal of Law and Psychiatry* 12, 189-201.

Preliminary attempt to monitor institutional careers of mentally disordered offenders over a relatively long period.

Menzies, R., & Webster, C. (1988). "Fixing Forensic Patients: Psychiatric Recommendations for Treatment in Pretrial Settings," *Behavioral Science & the Law* 6, no. 4, 453-478.

Investigates psychiatric recommendations for treatment at a clinical assessment agency providing evaluations of criminal defendants in Canada. Analysis of psychiatric reports and quantitative data demonstrated the saliency of treatment as a central forensic issue.

Menzies, R., & Webster, C. (1989). "Mental Disorder and Violent Crime," in *Pathway to Criminal Violence*. Ed. Neil Weiner & Marvin Wolfgang. Beverly Hills, Calif.: Sage.

Explores the relationship between mental disorder and violent criminality as they reflect current trends in criminological theory and practice and, in turn, as they are embodied in the ideologies, norms and mandates that govern the activities of judicial and clinical authorities.

Pelissier, B. (1988). "Mental Health Research in the Federal Bureau of Prisons: Current Trends and Future Developments," *Psychiatric Annals* 18, no. 12, 702-705.

Provides a synopsis of how mental health professionals have been involved in research within the Federal Bureau of Prisons of the United States. Also outlines the general function and importance of mental health research in the field of corrections and in mental health.

Prandoni, J., James, L., Kapit, R., & Ridley, B. (1985). "The Use of an Interagency Team Approach and Mental Health Referral Criteria to Improve the Effectiveness of Pre-Parole Mental Health Evaluation," *Journal of Offender Counselling, Services and Rehabilitation* 9, no. 4, 5-19.

Development of a program for preparole mental health screening, which involves the use of interagency, multidisciplinary teams and employs referral criteria based on mental health considerations.

Rice, M., & Harris, G. (1989). "Predictors of Insanity Acquittal," *Penetanguishene Mental Health Centre Research Report* 6, no. 2, 3-16.

A sample of insanity acquittees was compared to a randomly selected sample of persons accused of a criminal offence who were sent for a pretrial psychiatric evaluation and found not insane. The verdict varied according to the seriousness of index offence and whether the subject met the criteria for the diagnosis of psychosis.

Rogers, R., & Webster, C. (1989). "Assessing Treatability in Mentally Disordered Offenders," *Law and Human Behaviour* 13, no. 1, 19-27.

Argues for a radical rethinking of treatability within the criminal justice system as a complex task that tests the very limits of clinical competence.

Roman, D., & Gerbing, D. (1989). "The Mentally Disordered Criminal Offender: A Description Based on Demographic, Clinical and MMPI Data," *Journal of Clinical Psychology* 45, no. 6, 983-989.

An analysis suggests that factors such as sociopathy, substance abuse, psychoses with paranoid features and history of criminal activities distinguish male forensic state hospital patients from the benign mentally ill.

Scannel, T. (1989). "Community Care and the Difficult and Offender Patient," *British Journal of Psychiatry* 154, 615-619.

Proposes that the difficult and offender population in mental health care might act as a litmus test for the efficiency of deinstitutionalization and community care in general.

Shively, D., Marra, H., & Minaker, J. (1989). "Community Mental Health and Prisons: A Model for Constitutionally Adequate Care in Correctional Mental Health," *Journal of Criminal Justice* 17, 501-506.

Review of an experience by the State of Washington Department of Corrections in developing a constitutionally adequate mental health system.

Smith, L. (1988). "Comparing the Characteristics of Prison Inmates Who Require Psychiatric Hospitalization with the General Prison Population," *International Journal of Offender Therapy and Comparative Criminology* 32, no. 2, 123-133.

The research profiles 472 patients hospitalized during one year at Central New York Psychiatric Centre (the sole hospital facility for New York State's 40,000 sentenced inmates who require acute in-patient psychiatric care). Patients are compared with the state's general prison population with respect to demographic and criminal justice characteristics, such as age, sex, race, marital status, religion and education level.

Steadman, H., Rosenstein, M., MacAskill, L., & Mandercheid, R. (1988). "A Profile of Mentally Disordered Offenders Admitted to In-Patient Psychiatric Services in the United States," *Law and Human Behaviour* 12, no. 1, 91-99.

Presents data about mentally disordered offenders treated by in-patient psychiatric services in the United States. Data are derived from 1,980 admission surveys by the Survey and Reports Branch, National Institute of Mental Health.

Swetz, A., Brewer, F., Salive, M., & Stough, T. (1989). "The Prevalence of Mental Illness in a State Correctional Institution for Men," *Journal of Prison and Jail Health* 8, no. 1, 2-15.

Data indicating that a significant number of persons with psychiatric disabilities are incarcerated in Maryland's adult male correctional system.

Teplin, L., & Swartz, J. (1989). "Screening for Severe Mental Disorders in Jails," *Law and Human Behaviour* 13, no. 1, 2-18.

Outlines the development of the Referral Decision Scale (RDS), which detects persons who have a high probability of severe mental disorder so that they can be given a complete diagnostic evaluation.

Verdun-Jones, S. (1989). "Sentencing the Partly Mad and the Partly Bad: The Case of the Hospital Order in England and Wales," *International Journal of Law and Psychiatry* 12, 1-27.

Examines the approach adopted in England and Wales, where sentencing courts may impose a hospital order under which a

mentally disordered person convicted of an offence is sent directly to a hospital instead of a prison.

Wasyliw, O., Cavanaugh, J., & Grossman, L. (1988). "Clinical Considerations in the Community Treatment of Mentally Disordered Offenders," *International Journal of Law and Psychiatry* 13, 371-380.

Describes clinical considerations in the application of the major psychological and pharmacological treatment modalities for mentally disordered offenders. Environmental goals, resources and obstacles are discussed. ■

NATO
Advanced Study Institute
on
Crime and Mental Disorder

Tuscany, Italy
August 25 to September 4, 1991

The Advanced Study Institute will unite leading researchers from around the world to discuss recent findings about the relations between the various mental disorders, particularly the major disorders, and crime. Conceptual issues, questions of experimental design, and issues of measurement will all be addressed. Lecturers will include Sarnoff Mednick, John Monahan, Gerry Patterson, Lee Robins, Daisy Schalling, Fini Schulsinger, Saleem Shah, Hank Steadman, Linda Teplin, and C.D. Webster.

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