Solicitor General Canada

Solliciteur général Canada

THE GENERAL PROGRAM

FOR

THE DEVELOPMENT OF PSYCHIATRIC SERVICES

IN

FEDERAL CORRECTIONAL SERVICES

IN CANADA

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HON. WARREN ALLMAND
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General programme for the development of psychiatric services in federal correctional services in Canada / Canada. Advisory Board of Psychiatric Consultants.

Foreword

As Solicitor General I have made a careful study of the Report of the Advisory Board of Psychiatric Consultants and am profoundly impressed by the recommendations made by this authoritative body.

I, therefore, have requested the Canadian Penitentiary Service to develop its psychiatric services to assure that facilities are provided for the diagnosis, care, and treatment of acutely and severely ill inmates. Therapeutic psychiatric services will be provided on an out-patient basis to those inmates suffering from illnesses of a mild to moderate degree.

The objectives of the psychiatric program in the psychiatric program in the penitentiaries are being extended to provide psychiatric treatment to those whose criminal offences are related to latent or non-clinically evident psychiatric disorders and to administer medico-psychological therapy to inmates whose crimes and histories suggest the possibility of mental illnesses.

Full participation by psychiatrists in all relevant aspects of the penitentiary programs is another goal that I have set for the Canadian Penitentiary Service. Psychiatric reports and recommendations must be given due weight when rendering decisions on classifying inmates and assigning them to programs and on temporary absence and parole. Psychiatric staff will also be contributing to training programs for correctional staff and counselling institutional staff on the implementation of new training programs. I also look forward to the psychiatric services being encouraged and supported in the conduct of clinical investigation and evaluation.

In the development of psychiatric services, the Canadian Penitentiary Service has been given the following guidelines:

(a) to attain an unified psychiatric service within each geographical region of the Canadian Penitentiary Service.

(b) to provide psychiatric resources and programs appropriate to regional needs.

(c) to staff regional psychiatric services at a level that will ensure an acceptable standard of care.

(d) to provide adequate autonomous psychiatric facilities under medical direction in each region to accommodate inmates requiring hospital care and to serve as the professional base for the regional psychiatric services.

(e) to establish and maintain close liaison with universities for both training and research.

Already the Canadian Penitentiary Service has established a Regional Medical Centre in British Columbia and is renovating physical facilities for the Regional Medical Centres in Quebec and Ontario. Discussions will begin soon with appropriate provincial authorities to plan correctional medical centres in the Maritime and Prairie Regions.

While it appears to me that the aims and objectives recommended by the eminent Canadian psychiatrists who serve as my advisers are acceptable and deserving of public support, there are benefits to be gained from a broader expression of opinion. To facilitate study and discussion of the Report of the Advisory Board of Psychiatric Consultants, I am disseminating the report widely. Comments from individuals, groups and agencies with an interest in the treatment of criminal offenders in Canada will be welcomed and will aid the federal government in setting and maintaining high standards for psychiatric services in correctional institutions.

Warren Allmand,
Solicitor General of Canada.

OTTAWA, May 9, 1972

The Honourable Jean-Pierre Goyer, P.C., M.P.,
Solicitor General of Canada,
Sir Wilfrid Laurier Building,
340 Laurier Avenue West,
Ottawa, Ontario.

Sir:

The Advisory Board of Psychiatric Consultants appointed by you in August 1971 wishes to submit the attached report in response to the initial tasks assigned to it at that time.

This report is in the nature of a master plan for the further development of psychiatric services. It recommends a number of general principles and guidelines to direct development, as well as specific regional proposals. Before proceeding with further detailed planning the Board would welcome your consideration and decision on the broad policy recommendations and on the specific regional proposals.

In view of the many parties involved in reaching decisions and in coordinating such a specialized service into the overall correctional program the Board has attempted to provide considerable background information on the history, goals and objectives of correctional psychiatric services in general.

If the broad program is acceptable as policy we would urge distribution of the report on as wide a basis as possible to encourage constructive criticism and response to you and to your Advisory Board of Psychiatric Consultants.

Respectfully Yours,

F.C.R. Chalke, M.D.,
Chairman,
Advisory Board of Psychiatric
Consultants.

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SECTION 1

On August 13, 1971, the Solicitor General of Canada, the Honourable Jean-Pierre Goyer, announced the appointment of an Advisory Board of Psychiatric Consultants to advise him on the treatment of mentally ill inmates. The specific Terms of Reference of the Advisory Board are:

to determine

(a) the need for psychiatric services in each region to provide **total** treatment for mentally ill inmates;
(b) the program required to meet the needs for each category of mental illness:
  (i) whether in the institutions themselves, **or**
  (ii) by hospitalization in a psychiatric centre, **and**
  (iii) the staffing requirements in each case;
(c) the location of psychiatric centres, where required;
(d) the desirability and possibility of establishing training fellowships for psychiatrists and other means to provide the required professional staff on a continual basis;

to advise regarding

(e) affiliation with universities;
(f) the suitability of any existing facilities as psychiatric centres;

to provide

(g) general comments, where relevant, on the architectural design for any new psychiatric centre.

The members of the Advisory Board were appointed by the Solicitor General from nominations made by the Board of Directors of the Canadian Psychiatric Association. The members are representative of the areas of Canada in which penitentiary institutions are located.

The Advisory Board is constituted as follows:

CHAIRMAN: Dr. F.C.R. Chalke,
Associate Dean of Medicine,
Faculty of Medicine,
University of Ottawa,
Ottawa.

MEMBERS: Professor Robert O. Jones, M.D.,
Head of the Department of Psychiatry,
Dalhousie University,
Halifax.

Dr. Lionel Béliveau,
Medical Superintendent,
Philippe Pinel Institute,
Montreal.

Dr. C. Kenneth McKnight,
Chief of Forensic Services,
The Clarke Institute of Psychiatry,
Toronto.

Dr. Frank E. Coburn,
Chief of Forensic Psychiatry,
University of Saskatchewan,
Saskatoon, Sask.

Professor Anthony M. Marcus, M.D.,
Department of Psychiatry,
University of British Columbia,
Vancouver.

MEMBERS AT LARGE: Dr. Noel Garneau,
Cour du Bien Etre Social,
410 Bellechasse Street, East,
Montreal.

Dr. Colin M. Smith,
Executive Director,
Psychiatric Services Branch,
Department of Public Health,
Regina.

OBSERVERS: Dr. Daniel Craigen, Director of Medical Services
Dr. François Bisson, Regional Psychiatric, Quebec Region
Dr. George D. Scott, Psychiatrist, Ontario Region.

SECRETARY TO THE BOARD: Mr. George Koz, Research Associate,
Correctional Policy, Ministry of the Solicitor General.

Two economists were nominated by the Solicitor General and called upon to collaborate with the Advisory Board:

ECONOMISTS: Mr. Robert G. Hann,
Research Associate and Lecturer,
Centre of Criminology,
University of Toronto,
Toronto.

Mr. Richard S. Sullivan,
Assistant Professor,
Department of Economics,
Carleton University,
Ottawa.

METHODS OF WORK

The Advisory Board of Psychiatric Consultants has now met on eight occasions, in plenary session or in committee, to consider matters within its terms of reference.

Individual members of the Board were delegated to represent the appropriate regions in Canada and to consult with provincial government departments, universities and professional associations. The recommendations arising from these regions were subjected to critical appraisal by the Board and the names and offices of those consulted are listed in Appendices 1, 2, 3, 4, 5.

At the same time, the Board considered overall principles and developed methods for the collection of relevant data. This involved the development of criteria to categorize the patients for appropriate treatment programs. As a result of this step we now have current data which has been analysed in relation to each of the proposed regional programs. (see Appendix 6).

After a preliminary meeting between members of the National Parole Board and the Advisory Board, it was evident that much study and reorganization is needed to provide an integrated psychiatric service for federal offenders, while incarcerated and on parole.

It is considered that this service should form part of a continuum in which the inmate receives necessary psychiatric treatment, where detailed relevant investigation occurs prior to release with meaningful reports provided to the National Parole Board and where readily obtainable and continuing outpatient treatment is available during the parole period.

The development of such an adequate, integrated program for the offender is contingent upon a high level of professional services at each regional psychiatric centre.

A study of the comparative costs of a Regional Psychiatric Centre, appropriate mental hospitals and a maximum security institution, was conducted by the Director of Financial Services of the Canadian Penitentiary Service and this data is attached as Appendix 7. Extensive discussion took place with the economists regarding cost-benefits and cost-effectiveness and will be the subject of a complementary report to this document.

SECTION II

Historical Background

Psychiatric services in the Canadian Penitentiary Service were introduced in 1947 as a feature of a radical penal reform carried out after the Second World War and, specifically, to remedy a situation which had been continuously unsatisfactory during the previous hundred years. The involvement of Canadian penal services with the mentally disordered persons antedates Confederation – and the review of this involvement has a significant bearing on the subject-matter of this Report.

Since the early days of nineteenth century, Canadian prisons, jails and later penitentiaries, have been compelled to handle individuals variously described as feeble minded, epileptics, incorrigible, lunatics, or criminal lunatics. In the areas of both custody and treatment, very similar basic issues were of primary concern to the administrators of penal institutions in 1865 as they were pertinent in 1965. These issues – never adequately resolved – created problems and difficulties which have been perpetuated to the present day. The issues were, primarily, as follows:

- jurisdiction over certain groups of mentally disordered, which shifted from one level of government to the other, or was shared by both but without clear distinction as to respective responsibilities;
- Lack of appropriate classification of persons under custody, resulting in the mixing of mentally disordered with persons within the normal range of behaviour and/or interpersonal relationships;
- administrative difficulties originating from a non-segregated population and resulting in disruption of prison routine, undermining of discipline, outbursts of violence, abuse of the weak, etc.;
- inadequacy of facilities, primarily the lack of accommodation resulting in serious overcrowding; lack of suitable personnel for the care and treatment of patients;
- control of admission to a treatment facility.

Viewed in the historical perspective of nearly 150 years, the work of the Advisory Board of Psychiatric Consultants, covered by this Report, represents not only a scrutiny of the contemporary situation but is a continuation of sustained efforts across several generations, aimed at improving conditions long recognized as unsatisfactory.

The information presented has been abstracted from public documents issued under federal authority, and the selection has been deliberately limited to emphasize the evidence that the realization of unsatisfactory conditions regarding mentally disordered criminal offenders has been voiced by successive generations of local administrators and medical practitioners.

Part 1: Pre-psychiatric period – 19th century and the first half of the 20th century

1. *Period before 1850.* The expanding Province of Canada builds new public institutions for those citizens who were referred to as "unfortunates": the mentally afflicted and the criminally convicted. Thus, "lunatic asylums" are opened in Upper Canada (in Toronto, Orillia, Malden, Hamilton) and in Lower Canada (St. Jean, Beauport). Some 55-60 common jails are operated in the judicial districts of both parts of the Province; a central Provincial Penitentiary for adult offenders is built at Kingston, and two reformatories for juveniles, one for each Canada, opened at Penetanguishene and St. Vincent de Paul. The number of "lunatics" was always greater than the facilities available in the new asylums, and therefore many "lunatics" were kept in common jails regardless of whether they have

been convicted of a criminal offence or not. On completion of the Provincial Penitentiary (1835), "lunatic convicts" are detained in that institution, together with the "incorrigible" youngsters transferred from the two Provincial Reformatories.

"In the penitentiary at Kingston, 'lunatics' are kept in a 'dungeon' under conditions that leave little to the imagination. The 'dungeon' consisted of small, windowless, airless cubicles in the subterranean part of the building, on the level of the sewer emptying into Lake Ontario and occasionally flooded at high tides raised by south-westerly winds . . . ."

2. *Period 1850-1867.* The operation of the new penitentiary soon came under public criticism, and by 1849 the "scandal of Kingston Pen." broke open, leading to the Commission of Inquiry under George Brown. As a result of this public intervention into what has been described as "barbarous conditions at the penitentiary", an Act of the Provincial Legislature was promulgated in 1852 aimed at improving the administration of the penitentiary; and a Criminal Lunatic Asylum was built at Rockwood in the neighbouring village of Portsmouth, for the specific purpose of keeping the "lunatic convicts" separated from general penitentiary population. Rockwood Asylum opened in 1855 and as soon as accommodation became available, the "lunatics" from common jails were transferred there, for humanitarian reasons, and eventually the "lunatic convicts" became only a small group of patients in that institution. The original building was expanded, but overcrowding followed quickly, and few years after the opening of Rockwood Asylum, the Warden of Kingston Penitentiary reported that he still had custody of . . ." nine lunatic convicts who must be kept in the criminal lunatic asylum within the walls . . . [the dungeon]" because Rockwood Asylum became overcrowded and was short of accommodation for the very persons for whom it has been built. Ten years after the opening of Rockwood Asylum, its Medical Superintendant wrote:

> ". . . Some 130 patients were treated during 1865 . . . Last year, the proportion of deaths was 9%, and the mortality was chiefly confined to those patients who had been immured for successive years in the underground apartments beneath the Penitentiary. . . ."
>
> Annual Report of the Board of Inspectors of Prisons and Asylums, 1865

The reports of the Medical Superintendent of Rockwood at this period indicate very advanced views (in today's terms) and a clear realization of the needs of mental patients, from the medical point of view and from the standpoint of effectiveness of public services: namely, the necessity of classification of patients into distinctive categories, their segregation through diversified institutions and the establishment of two distinct classes of asylums, one for the curable patients, and the other for the incurable insane. The medical opinion expressed in 1865 has been recorded as follows:

> ". . . The insane can never be comfortably and satisfactorily governed and provided for under any other regime than that which obtains in a well-ordered and efficient curative institution; and this regimen, I feel convinced, cannot be perpetuated in full integrity in establishments organized and conducted on almhouse or penitentiary principles. . .
>
> The curative asylums are, in the first place, indispensable . . . they should be appropriate to the reception and treatment of recent acute cases and, secondly, of those chronic cases of a dangerous and violent character which, though not likely to be cured, may nevertheless be improved by the discipline of a curative asylum and brought into such condition of quietude and subordination as to fit them for residence in a less expensive institution.
>
> Indeed, it is my impression that, if possible, every case of insanity requiring asylum lodgement should be sent for a certain term to a curative institution, as the training there received by lunatics could hardly be imparted elsewhere, and it would be most undesirable that

the tranquility of secondary establishments be disturbed by undisciplined and turbulent inmates. Disregard of this condition would very probably rapidly destroy . . . or impair the discipline of such institutions.

. . . The greatest benefit which can be conferred on the insane is their restoration to reason; and this is also the greatest benefit that can be conferred upon the community . . . Every measure of legislation purporting to be for the relief of the insane should have this primary reference. If ten insane persons can be cured at the same expense as one uncured insane person can be supported for life while in custody, it is very clear that the public interests are best consulted by so administering our insane hospitals as to render them most efficient in the cure of insanity . . ."

Annual Report of the Board of Inspectors of
Prison and Asylums, 1865

3. *Period 1867-1880.* Upon Confederation, responsibility for penal institutions was divided between the federal and provincial governments, while "lunatic asylums" came under provincial jurisdiction. However, the Rockwood Asylum was an exception, as it was declared as part of the Kingston Penitentiary. From that moment on, the two major issues, that of jurisdiction and the control of admissions, became a source of difficulties. In the first report after Confederation, the Medical Superintendent of Rockwood wrote:

"... The arrangements made by the Provincial with the Dominion Government for the reception into the Rockwood Asylum of the unfortunate lunatics confined into gaols of Ontario was a most human one; but while it has relieved many of the gaols of a most troublesome inmates, it has also been the means of sending a great many cases to this institution that had been refused admission to other asylums in the Province, and not only have the gaols been thus relieved but also the asylums in the western part of the Province have relieved themselves of the care of five dangerous and troublesome lunatics, and the responsibility of taking charge of these cases has been transferred to the officers of this federal Asylum . . .

I wish to place these facts on record, not in any complaining or captious spirit but merely for the purpose of showing that, whilst the superintendents of other asylums have had the privilege of selecting the most suitable cases for successful treatment, we have of necessity been obliged to admit indiscrimimately all who were sent; and therefore the number of unpromising cases in this asylum must for many years to come be vastly in excess of a similar class of cases to be found in any other asylum in the Province or Dominion . . ."

Annual Report of the Director of Penitentiaries,
1868

Within a decade after Confederation, the operation of Rockwood Asylum under penitentiary administration became, in turn, a matter of public criticism and the two levels of governments finally came to an agreement, whereby the Province of Ontario took over Rockwood Asylum, while the criminally convicted lunatics were transferred back to Kingston Penitentiary (in 1877) where they were accommodated at the institutional hospital. The "insane ward" in the hospital took nearly all accommodation available, leaving only three cells for the routinely sick patients. The construction of a new facility for the insane lasted for over four years.

4. *Period 1881-1916.* By 1881, the new "Asylum for Insane Criminals" had been built within the walls of Kingston Penitentiary, and this period marks the life of that asylum. The Administration was quite proud of the new facility:

"... It is a splendid building, well suited for its purpose . . . and the dungeon cells are large, well aired and rendered extra strong . . ."

However, medical opinion clearly expressed some doubts as to the appropriateness of the new facility receiving patients from the penitentiaries at Kingston, St. Vincent de Paul and Dorchester:

> "... (in these penitentiaries) there is a large number of convicts of the idiotic and imbecile types. Many of them are incapable of self-control, and should be inmates of some other asylums rather than of a Penitentiary, where they would receive proper care and treatment... Most of these convicts are either men of originally feeble constitutions, or the subjects of diseases or infirmities which have been contracted through circumstances over which they have had not control..."
>
> Annual Report of the Inspector of Penitentiaries, 1881; report by the Surgeon of Kingston Penitentiary

By the end of the 19th century, medical opinion was expressed in more precise terms regarding the effectiveness of treatment and the inappropriateness of penal environment:

> "... The more enlightened views which obtain now concerning the nature of insanity, assure us that it is a disease like any other disease, and can be treated on well known principles which must be fulfilled... An amount of personal liberty to the insane, commensurate with their own and their attendants' safety is necessary for treating insanity under its modern conception..."
>
> Annual Report of the Inspector of Penitentiaries, 1899: report by Dr. Daniel Phelan, Surgeon of Kingston Penitentiary.

The steadily increasing population of the insane ward at Kingston, and the presence within the unsegregated population in penitentiaries of "lunatics" who could not be admitted to the insane ward, was giving rise to considerable administrative difficulties, and a sustained campaign developed for the removal of "insane criminals" from the penitentiary altogether. In 1891, or barely ten years after the opening of the new facility, the Warden of Kingston Penitentiary wrote in his annual report:

> "... I have already given my opinion as to the great necessity there exists that a building for the occupation of these unfortunate beings, with ample grounds attached, should be erected outside the penitentiary walls..."

Thus, in the many years to come, the successive Wardens of Kingston Penitentiary became the outspoken promoters for a better deal for mentally disordered offenders placed in their custody. Their opinion came to the support of medical views in this regard, and by 1908 the Warden of Kingston Penitentiary wrote about the Insane Ward in these terms:

> "... To this miserable abode, the most antiquated of our prison structure, are consigned the irresponsible unfortunates whose crimes led to insanity or whose insanity led to crimes. The cells remain as they were originally constructed ($8^1/_2$ by $2^1/_2$ by 6) [sic] while every other cell-block has been demolished and rebuilt with compartments twice the size of the old cells and equipped according to modern ideas of sanitation and confort...
>
> The Ward-for-the-Insane runs parallel with the prison wall between which and the buildings runs the exercise yard allotted to the inmates. Stone walls in any direction they may look unless they look upward to the sky. In winter and during inclement weather, the few hours they are released from their cells they spend in one large dingy, unsanitary room where they mingle promiscuously, with no entertainment except reading and playing checkers. They have no hospital oversight, no trained attendants, nothing in fact but prison police who lock and unlock the doors and follow them into the yard and back again to their cells in endless monotonous routine..."

5. In 1913 a Royal Commission was appointed to investigate the management of Kingston Penitentiary. In turn, the Commission requested Dr. E. Young of the Rockwood Mental Hospital to inquire into and report on the Insane Ward at Kingston. Dr. Young found as follows:

> ". . . The building in which the insane are at present housed is, in my opinion, entirely unsuited to the purpose for which it is used. It is defective in structural arrangements, lacking in nursing and medical facilities and devoid of means of providing occupation. The physical condition of the patients shows the effect of improper diet, insufficient exercise and being deprived of fresh air . . .
>
> Each patient is locked in his cell, without proper sanitary conveniences, from 4 p.m. to 7 a.m.; the door of each cell is simply a grating, and there is no provision for the isolation and care of the noisy and filthy patients . . .
>
> There is no provision for the proper classification of patients, all of whom are gathered together in large day room, the acute with the chronic the old and helpless with the impulsive and violent, the lucid with the demented . . ."

In addition to the medical aspects, the 1913 Commission considered also the problem of criminal recidivism as connected with the issue of mental deficiency:

> ". . . There is admittedly a close relationship between mental deficiency and insanity, and crime. The proportion of defectives shown by an investigation . . . in reformatories of New York, New Jersey and Illinois . . . is 30%. In other institutions . . . 50% of the inmates is found to be defective. In our country, this aspect of the question of crime has received no consideration. No care is taken to ensure the detection of defectives and no provision is made for their custody and training. They are not understood by the Courts or by prison officers. They are sentenced, imprisoned, discharged and re-sentenced, at great expense to the country. When in prison, they prove a source of constant worry and renter the maintenance of prison discipline difficult or impossible . . . These questions press for consideration and the first step would be the employment of a physician trained in psychiatry, who could advise the Government in regard to these and associated questions . . ." [this last recommendation had to wait 35 years to be implemented.]

In the aftermath of the 1913 Royal Commission, the Insane Ward at Kingston Penitentiary was disbanded and the patients transferred to provincial custody, as of Dominion Day 1916.

6. *Period 1916-1946.* Very scant information is available from the period of the first World War and the years following it. In 1921, the Minister of Justice appointed a Commission of Inquiry, which found the conditions regarding mentally disordered offenders as follows:

> ". . . The existing provisions on the subject of insane prisoners are not satisfactory and indicate an obsolete and unscientific view of mental diseases. In their visits to the penitentiaries nothing has more powerfully impressed the Committee than the inefficiency of the present practice . . . and no amendment proposed to the Penitentiary Act is, in the Committee's opinion, more important than that now recommended (regarding the disposition of mentally disordered offenders) . . ."

The Committee suggested legislative measures for the control of admission to penitentiaries of mentally afflicted offenders, and their disposition after the expiration of sentence. It also recommended legislative provisions to facilitate care and treatment:

> ". . . Sec. 55: . . . The regulations made under this [proposed] Act may authorize the employment, for the examination, treatment or care of

any convict who is seriously ill, either physically or mentally, of such specialists and nurses as are necessary in the circumstances, and the medical supervision of any penitentiary may be entrusted to the faculty of medicine of any recognized university . . ."

The following year, 1922, the newly appointed Superintendent of Penitentiaries, W. S. Hughes, made numerous recommendations for the improvement of the Penitentiary Service and he advocated, among other things, the opening of a penitentiary mental hospital:

". . . At the present time those mentally diseased are transferred to some of the mental hospitals under the control of the Provinces. Great difficulty is experienced in prevailing upon some of the provincial governments to receive these unfortunates, and not infrequently they are retained in the penitentiary for long periods before being removed. In some cases, very troublesome patients are returned to the penitentiary, although pronounced by the Dominion Government alienists as hopelessly insane. It would appear that the closing of the Insane Ward operated at Kingston Penitentiary until 1915 was a serious mistake. There should be a properly constructed and operated mental hospital provided as speedily as possible for these unfortunates . . ."

Superintendent Hughes repeated his recommendations for the re-opening of the "Penitentiary Mental Disease Hospital", in every annual report until 1930. However, the recommendations were not heeded, and after his departure there was yet another period of apparent stagnation and neglect in penitentiary administration, giving rise to the Royal Commission of 1938 whose findings were published as the Archambault Report.

7. *Archambault Report.* Under the heading "Medical Services", the 1938 Royal Commission spoke in terms of effectiveness of correctional services:

". . . Nothing should be omitted which might improve the character of the prisoner . . . Proper treatment should follow in an effort to remove the causes of his criminal tendencies. Quite apart from the humanitarian consideration, the question of greater national economy is involved here, because . . . the cost of maintaining a prisoner in the penitentiary is high and, if he can be cured, he ceases to be a charge on the state, and becomes instead an asset.
From any point of view it is necessary that a full-time physician and a full-time psychiatrist should be provided for the larger institutions . . . and part-time physicians and part-time psychiatrists for the smaller ones . . ."

Archambault Report, page 120

In Chapter XI, under the heading "Treatment of Insane Prisoners", the Archambault Commission dealt primarily with the legal aspect of handling mentally afflicted persons. However, the chapter ends with a plea:

". . . It is a grave reflection on our penal system that several insane prisoners should be confined in our penitentiaries, caged like wild beasts, where there is neither means for proper treatment nor personnel with experience to deal with them."

Unfortunately, the Second World War intervened and delayed penal reform. During the war years it was again the Warden of Kingston Penitentiary who repeatedly reported the difficulties with insane prisoners and kept alive the request for a mental hospital:

". . . If more satisfactory arrangements cannot be arrived at [between the governments], it would seem that it will be necessary for the Penitentiary Branch to consider the erection of an insane ward to be

administered and controlled by the penitentiary officials under the supervision of a qualified psychiatrist . . ."

Annual Report, 1940 – 1946

Part 2: Period of Psychiatric Services: 1946-1970

8. *Period 1946-1960.* With the war over, Major-General Ralph Gibson was appointed as Commissioner of Penitentiaries in 1946, and the 14 years of his administration saw the birth and spontaneous expansion of psychiatric services within the Penitentiary Service.

The central psychiatric facility, consisting of a small psychiatric ward (with nine cells) at Kingston Penitentiary, was opened in 1948. It soon experienced the traditional problem of pressure for more accommodation and over the next decade the accommodation was expanded to 42 beds. With the appointment of the first full-time psychiatrist in Kingston in 1959, the psychiatric ward was relocated to its present building. At St. Vincent de Paul Penitentiary, a part-time psychiatrist assumed duties in 1956 and a new psychiatric ward opened in 1959. In other regions, part-time psychiatrists were added to the staff of maximum-security penitentiaries.

The Annual Reports for the decade 1950-1960 are rich in the description of developing psychiatric services, the methods of treatment used and the comparative value of different methods and techniques. Under the heading of psychiatric services, it is evident from the annual reports that local practitioners had full opportunity to report both on their achievements and on limitations of prevailing conditions.

9. *Fauteux Report and Royal Commission on Sexual Psychopaths:*

This important period is also marked by the publication of two major reports, originating from commissions of inquiry: the Fauteux Report of 1956 and the report of the Royal Commission on Sexual Psychopaths of 1958. Both reports emphasized the need for special facilities for the care and treatment of special categories of offenders: alcoholics, drug-addicts, sex offenders, and psychopaths. In particular, the Royal Commission noted that the federal government did not provide any special treatment for psychopathic sexual offenders although the amendment to the Criminal Code introducing preventive detention for this class of offender clearly intended that remedial treatment would be provided. Selected recommendations of both reports are given in Appendix 8.

10. *Period 1960-1970.* The Penitentiary Service was re-organized under Commissioner Allen MacLeod, following the two-year study of the Correctional Planning Committee (whose report was never made public). The "Ten Year Plan" of constructing new penitentiaries was developed and commenced in 1963. One feature of this plan was the construction of Regional Medical Centres, each one to be provided with a psychiatric facility. This part of the Ten-Year Plan still awaits implementation.

A change in annual reporting took place during this administration. Instead of each institutional Warden making his report (which) included accounting by the medical practitioners for their share in the institutional effort, each divisional director in Ottawa wrote a section on the general activities of his division. Thus the remarks on psychiatric services for the years 1962 and 1963 were reduced to three or four lines, concentrating on the now familiar issues, e.g.

"Not enough psychiatrists and psychologists are available to fill adequately the needs of most institutions. This may be due to nation-wide shortage of qualified persons in these two specialties which can play an important role in the correction of deviant behaviour."

quote from 1963 Report of the Commissioner of Penitentiaries, page 43

The more extensive reports in the following years repeat the same state of affairs:

> "... Psychiatric Services cannot be provided on the scale desirable to meet the inmate demand. Adequate numbers of personnel and treatment space are lacking ... The need for psychiatric services is obvious when one considers that 45% of the inmate population have interviews with the psychiatrist, either voluntarily or on referral ...
>
> The need for Psychiatric Centres within the penal system which could provide the proper facilities for adequate treatment and rehabilitation can perhaps best be demonstrated by pointing out that, in one of the penitentiaries, one inmate out of every nine has been a former patient of mental hospital. A future breakdown in the mental condition of such inmates is always a possibility, particularly when they have to endure the stresses normally associated with incarceration. The need for greater psychiatric facilities is urgent now and can only increase with time."
>
> Annual Report of the Commissioner of Penitentiaries, 1966, page 29

11. *Ouimet Report.* The decade 1960-1970 was also marked by the study conducted by the Canadian Committee on Corrections which reported in 1969. Two chapters of the report, known, after its chairman, as the Ouimet Report, deal exclusively with the issues involving psychiatric services. Chapter 12 is devoted mainly to the medico-legal aspects of mentally disordered persons who face criminal charges; that is, it concerns the provision of psychiatric services to criminal courts. Nevertheless, the same chapter considered also the issues resulting from detention of mentally disordered offenders, whether in correctional institutions or mental hospitals. In the general principles and the specific recommendations, the Ouimet Report has emphasized that new and vastly improved psychiatric facilities will be required under the concept of a 'just society', if such society is to fulfil its obligation to all handicapped offenders.

Chapter 13 of Ouimet Report deals with the problem of the dangerous offender, and in offering a solution to the presently unsatisfactory practice, the report suggested a new legal definition of dangerous offenders, and also proposed the utilization by the courts of clinical assessment of the degrees of dangerousness. It is evident that whether in correctional institutions or mental hospitals existing psychiatric facilities in Canada could not fully cope with the task expected of them under the scheme contemplated by the Report, and that new diagnostic facilities would be required should the federal government adopt the Ouimet recommendations regarding dangerous offenders.

12. *Closing years.* The seventh decade of this century, which incidentally has closed another chapter in penitentiary administration, ended with the familiar statement in the annual report, now rendered by the Solicitor General:

> "... The demand and need for psychiatric services remains high and the individual psychiatrists working in penitentiaries are over-burdened by increasing requests for psychiatric reports, assessments, psychotherapy and other forms of treatment ... The construction of the Regional Medical Centres appears to offer a possible solution to this problem and may enable more patients to be treated with a greater diversity of treatment modalities. It is also probable that the provision of modern treatment facilities may challenge more psychiatrists to develop an interest in working in this area of psychiatry."
>
> Annual Report of the Solicitor General 1970, page 55

The historical review of the federal involvement with mentally disordered persons ends with the most promising development in the past 150 years: in 1971, the Honourable Jean-Pierre Goyer, the minister responsible for federal correctional services, appointed an Advisory Board of Psychiatric Consultants to advise him on the treatment of mentally disordered penitentiary inmates.

SECTION III

The Objectives of Correctional Psychiatric Services

The objectives of a Psychiatric Service to any correctional system have been identified in various jurisdictions in several ways.

(I) As part of the general medical services with whatever objectives and responsibilities are assigned to that service.

(II) In terms of the objectives to be achieved.

(III) In terms of the roles of the professional staff.

(IV) In terms of the patients requiring care and treatment.

(I) PSYCHIATRIC SERVICES AS SPECIALTY MEDICAL SERVICES:

The psychiatric services function in one aspect as part of the general medical services and should conform, in that part to the goals and objectives of the medical service.

Experience has demonstrated however that it is difficult and unduly constraining to limit psychiatric services to operating solely as a specialty within a medical service in a correctional setting as illustrated by the following proposed functions.

(II) THE OBJECTIVES OF A PSYCHIATRIC SERVICE IN A CORRECTIONAL SYSTEM WOULD INCLUDE:

Clinical Services:

(1) Provision of services for the diagnosis of psychiatric illness;

(2) The arranging for psychiatric care and treatment for the acutely or severely ill;

(3) The provision of psychiatric care and treatment for the acutely and severely ill, as the resources permit;

(4) The assessment and supervision of programs for those who suffer psychiatric disabilities;

(5) The provision of therapeutic psychiatric services (drugs, behaviour therapies, psychotherapy) on an ambulatory basis for those suffering from illnesses of mild to moderate severity;

(6) The provision of psychiatric reports and recommendations when required for classification, program assignments, temporary absences, releases on parole, etc.;

(7) The provision of psychiatric treatment for those not manifestly clinically ill, but where the offence or offences clearly arise from underlying psychopathology, e.g. masked depression, latent schizophrenia, some personality disorders;

(8) The provision of medico-psychological therapy on a trial basis for those whose offences appear to arise from, or be related to behaviour disorders, e.g. fire setting, incest, drug addiction;

(9) The provision of psychiatric after-care, follow-up and continuing medical treatment for those on parole and those under the care of voluntary after-care societies;

Advisory Services:

(10) Acting as advisors to the administrators of institutions regarding mental health aspects of practices, procedures and programs with a view to reducing psychiatric illnesses of a preventable nature by ameliorating tensions arising from isolation, physical threat, dependency status;

(11) The provision of psychiatric counsel to staff in regard to emotional problems involved in staff-inmate relations, working conditions, and changing programs. Psychiatric consultations may be particularly useful in resolving difficulties which inevitably arise in new approaches as in Living Units;

(12) The provision of consultations and reports, regarding pre-release and parole, to the parole staff and to personnel of after-care agencies concerning mental health needs and problems to be faced by inmates with psychiatric disabilities after their parole or release;

Training Services:

(13) The provision of on-the-job staff training for custodial and correctional staff with respect to matters within the competence of the psychiatric service professionals, e.g., detecting suicidal risks, management of impulsive or violent behaviour, recognition of symptoms of an approaching crisis;

(14) The provision of appropriate training programs for universities and other educational institutions in the field of psychiatry as applied in the correctional field, for psychiatric residents, nurses, clinical psychologists, therapists;

Research Services

(15) Engaging in research in relevant fields of psychiatric criminology, penology of abnormal offenders, research methodology, etc.

(III) ROLE AND FUNCTION OF THE PSYCHIATRIC TEAM:

The functions of the psychiatrist and his associated professionals within the correctional framework are:

(1) To act as specialist consultants to the medical services of institutions regarding diagnosis and treatment;

(2) To provide the medically necessary treatment for identified psychiatric patients in the prison population either on an ambulatory basis or when available in appropriate infirmary settings;

(3) To arrange for medically necessary transfers to outside hospitals with adequate professional liaison with the treating psychiatrist both before and after treatment;

(4) To assist, in a consultant capacity, the classification officers with regard to diagnosis, limitations because of psychiatric impairment and prognosis in relation to institutional allocation and programs.

(5) To assist in the development and operation of programs for the management of the psychiatrically impaired while they are undergoing sentence.

(6) To act as advisor to Regional Directors and Directors of institutions in relation to the development of institutional rehabilitation programs and also in relation to all matters affecting the mental health of inmates.

Few would question the place of the psychiatric profession in fulfilling the first five listed above, or in providing treatment and care for inmates who are psychiatrically

ill on admission or who develop illness during incarceration. (These categories are described in detail in Objective IV. Goals in Terms of Patients Requiring Care.)

However, for many reasons, as pointed out by Satten(*), the psychiatrist's role in correctional services is not fully acknowledged and he states:

> "What does the psychiatrist bring to the correctional scene? First and foremost, he brings the healing tradition of the physician which, in its best moments, has transcended national boundaries and social prejudices and which is especially important in the treatment of social outcasts. He also brings, as mentioned earlier, the administrative know-how of running a treatment institution that depends for its success on the continuing education of relatively untrained personnel. Finally, he brings a highly technical knowledge of what makes a given individual think, feel, and act the way he does, and the ability to work with highly trained professionals from other disciplines in translating their joint knowledge into an effective treatment program. While most, if not all of the treatment skills can be learned by various members of the team, the important problem is that of assigning the person requiring treatment to the "right" treatment.
>
> In a broad sense, this is what one might call diagnosis. The ability to do this, to integrate the findings from all the professions about the behaviour of a given person and to make proper recommendations about further treatment is *the key role for which psychiatrists are trained today; it is also a role for which no other profession is currently being trained.* On the other hand, many professions are training individuals to do treatment, and these individuals have demonstrated that they can do so quite successfully when given appropriate patients or clients. For example, many clinical psychologists and psychiatric social workers are doing psychotherapy, many ministers are doing counseling, and many nurses and activities therapists are broadening their roles much beyond their original training.
>
> At this point, however, one cannot define in detail the various roles of the psychiatrist, other than to state they will relate to his special knowledge and his special skills. The exact role will vary in different correctional institutions, much as it does in different mental hospitals or even within the same mental hospital. In a broad sense, the psychiatrist's role is to make his special knowledge part of the professional common sense of the personnel that function in the institution.
>
> The exact administrative arrangements by which such a contribution may be made will probably vary considerably from place to place, and may often depend upon expediency. For example, what psychiatrist is available and how much time does he have for correctional work? But if the concept of rehabilitation is truly accepted, psychiatric services will be seen as essential, and ways will be found to use the psychiatrist effectively. Whether the psychiatrist is used as a consultant, as an institutional staff person, as director of clinical services, or even as a superintendent of an institution, is less important than whether the correctional system is actually trying to make use of his knowledge and skills."

This in no way implies that the psychiatrist is necessarily master of all the diagnostic, observational skills on one hand nor of the range of therapeutic skills on the other. Conventional wisdom at this time tends to assign to him the managerial functions in the therapeutic milieu, but this should be clearly separated from his function as the clinically skilled descriptive analyst in the scientific mode, seeking to explain and alter abnormal behaviour.

Beyond the clearly medical care responsibility of the psychiatrist as a consultant to the prison medical service, questions have been raised as to "why a psychiatrist for

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(*) J. Satten "The Psychiatrist's Function in the Correctional Setting", *Prison Journal* V.44, Page 13, 1964.

some of the more general or scientific correctional programs? "The answer lies in the particular combination of basic science knowledge and clinical skills and in the responsibilities and ethical constraints of the psychiatrist as a physician. His knowledge bridges the biological, psychological and social aspects of man in his environment and the interrelations of this knowledge. Only the psychiatrist has a healing commitment based on skills derived from all these sciences.

At this stage, there may be only a few facts knonw on which we can clearly discriminate a therapeutic role in corrections, e.g., masked depression is a factor in some homicides. The emerging factors on a biological level etiologically related to violence*, the effect of chemical agents on behaviour,** the multifactorial facets contributing to aberrant behaviour, the requirement of clinical skills to elicit data make the psychiatrist and clinical neuro-psychologist nodal contributors to study the problems of psychopathology. Thus the psychiatrist and clinical neuro-psychologist are the only clinical investigators capable of correlating the knowledge from the different behavioural sciences, from the molecular to the cultural levels of complexity, and relating these to specific behavious, attitudes or motives.

(IV) GOALS IN TERMS OF PATIENTS REQUIRING CARE:

Within the Canadian penitentiary population, there is a number of inmates who suffer from various types of mental illness – some with lifelong disabilities, some whose illness is present on admission and others who develop illness after incarceration (4 per cent of all inmates in the U.S. Federal Prison system develop their first attack of psychosis while under sentence).

The total number with diagnosed psychiatric illness at any one time in Canadian Penitentiaries illness approximates 750, and gives an estimate of the numbers and categories involved, as of October 1971. The figure of 750 does not include the Special Program Group. (See D. below).

A. The Acutely Ill – severe depressions, psychoses, panic attacks, confusional states or toxic reactions requiring medical diagnosis and hospital treatment under medical direction. This group of patients normally would not be expected to be in hospital more than two months in any one attack.

This group, clearly ill, is capable of being treated adequately only in a medical setting, and has the top priority for any available psychiatric services. (In the specific Canadian setting this represents, at any one point in time, about 76 patients).

B. Sub-Acute Cases – The cases in this group are in similar diagnostic categories to those in Group A but their illness persists in treatable form after the acute phase has passed and therefore active treatment must continue beyond the two month period, often with specialized nursing attention. In some cases outside penitentiary, these patients can be treated in day hospitals or on a regular outpatient basis, provided a relatively stress-free living arrangement is found. In penitentiary, however, it is medically advisable that treatment be provided to the maximum degree of improvement in the controlled environment of the hospital centre. (In the specific Canadian setting this represents, at any one point in time, about 303 patients).

C. Chronic Patients – These cases would require continuing psychiatric care and would include, for example, organic impairment due to brain damage, chronic schizophrenia, some epileptics and some cases with mental retardation. These patients cannot live a

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(*) *Violence and Brain,* Mark and Even, New York, Evanstar and London, Harper and Row.

(**) *The Physiology of Agression and Defeat,* B.E. Eleftherion and J.B. Scott, Plenum Publishing Co., N.Y.

normal prison life as they create serious administrative problems; both the patients and the general population suffer from their inclusion in the normal population and they are basically a medical problem.

It is considered that it is a valid objective of psychiatric centres to take responsibility for chronically ill patients. Even if some chronic psychotics may not respond to known treatment methods, benefits will accrue to the rest of general population through amelioration of the environment by the removal of chronic psychiatric cases. It is considered that the creation of chronic units to treat such patients is justifiable. (In the specific Canadian setting some 370 inmates have been identified in this category).

D. Group Requiring Special Programs: — personality disorders, drug addicts and alcoholics, sexual offenders and dangerous sexual offenders.

A certain percentage of the cases in this category would be suffering from such illnesses as masked depression and masked schizophrenia where the crime is significantly related to the underlying illness. Clinical opinion is that this group is responsive to treatment and that treatment would enable them to be discharged from prison at an earlier date. Clinical opinion also considers that many Dangerous Sexual Offenders have been wrongly classified as such and that an extensive rescreening and reappraisal of the people in this category might result in reclassification and possible earlier discharge. It must, however, be stated that, while treatment programs exist which could be utilized for the remaining inmates in these categories, a study of the literature has not revealed any adequate follow-up studies to enable us to adequately evaluate the outcome of such treatment. It is, therefore, essential that evaluative research be built into any proposed program. (While no accurate estimate of the number of inmates in this group can be presently provided, an estimate of 1,000 has been made, and it is not suggested that accommodation be provided to treat them in such volume).

SECTION IV

Present Developments in Other Nations

Almost all countries of the Western World have had, over the past 50 years, to confront the situation of the mentally abnormal offender. The developments for coping with the problem have been varied and none has emerged as pre-eminently superior. Canada appears to be unique in having its correctional system split arbitrarily into federal and provincial jurisdictions based on severity of sentence. The United States on the other hand has parallel federal and state correctional systems based on the nature of the crime.

In 1957 the United Nations surveyed most Western European Countries to determine the legal machinery that existed for the custody and care of those found to be suffering from mental illness while under sentence.(*) The laws and procedures appear strikingly similar but little is known of the facilities or implementation in many of these countries.

Whether or not a full range of treatment facilities are developed within the jurisdiction of the nation's penal system through cooperation with the normal health system of the state seems equally variable. Some "hospital prisons" such as Broadmoor in the United Kingdom have been transferred between the Home Office and the Ministry of Health, even though both Health Services and Corrections fall under national ministries.

In the United States the most common solution has been the transfer of mentally ill offenders from state correction institutions to state operated mental hospitals.(**) In most instances the mental hospitals provided or continue to provide security units for ill prisoners under sentence in state correctional institutions together with accommodation for persons unfit to stand trial, or not guilty because of insanity. In a few instances the state correction services operate a psychiatric hospital under its own jurisdiction and of course the federal prison system has several such hospitals.(**)

The range of services provided in these correction hospitals, their staffing patterns and ratios and their objectives vary widely and no data exist upon which to judge them except that almost all complain of professional staff shortages based either on non-availability or budgetary constraints.

Some of the more notable United States correctional hospitals that have contributed valuable information on the type, characteristics and response to treatment programs of the mentally ill offender are the United States penitentiary hospitals at Leavenworth and at Springfield, the Michigan Corrections Psychiatric Clinic at Jackson, Clinton Prison in New York, and the California Medical Facility in Vacaville.(***)

Each State seems to have been faced with the range of cases identifiable in our penitentiaries, and evolved compromise solutions with no particular system emerging as optimal.

Some countries have established special facilities for the social or antisocial character-disordered offender which have received world recognition as pioneering resources to solve a universal problem. The best known of these, Herstedvester in Denmark, Van der Hoeven Klinik in the Netherlands, Grendon Psychiatric Prison in the

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(*) *International Review of Criminal Police,* No. 12, July 1957, p. 3. United Nations Publication 58, IV.I.

(**) P.L. Schiedemandel and C.K. Kanno *The Mentally Ill Offender — A Survey of Treatment Programs.* The Joint Information Service, APA, NAMA Washington, D.C. 1969.

(***) *The Mentally Abnormal Offender.* CIBA Foundation Symposium, London 1967.

United Kingdom and Patuxent in the United States have concentrated both personnel, research facilities and training in a way that has permitted them up to now to fulfil a pioneering role.

Other countries, by their pioneering undertakings, have contributed to our knowledge and it would be appropriate for us in Canada to carry out further developments on our own. Moreover, cross-cultural trends in other countries are different from those in Canada, and therefore, we cannot directly adopt methods developed abroad: we must find out truly Canadian practices appropriate to our penal code, the type of offenders in Canada and the socio-cultural patterns of Canadian people.

SECTION V

The Developments required to Fulfil the Objectives in Canada on the Federal Level

Repeated surveys(*) have indicated inadequate facilities for the proper care of psychiatric patients in almost all federal prisons across Canada. The recent studies of the Regional Representatives of the Advisory Board of Psychiatric Consultants confirm this deficiency and indicate the progressive deterioration of such facilities as do exist.

Part I – ALTERNATIVES

Before embarking on major new construction it is necessary to examine the alternatives that have been suggested, considered by the Board and rejected for the reasons stated below:

Alternative 1: The transfer of all inmates with any significant psychiatric illness, disability or disorder to the care of the provincial health services. This possibility has been repeatedly explored over the past few years and has been found unacceptable by nearly every province for a number of reasons:

(a) Very few hospitals will undertake to provide any degree of custodial supervision and those that do have small secure units are already overcrowded.

(b) Many of the cases do not fall within the categories or types of illness presently being treated in provincial hospitals.

(c) Inmates may be motivated by the secondary gains of outside hospitalization to exaggerate or prolong illness.

(d) Inmates will be returned in many cases when acute illnesses subside without adequate services in the penitentiaries to continue their rehabilitation or to assign them to correctional programs within the tolerance of their limitations.

Alternative 2: The establishment of one large, centrally located psychiatric prison hospital under federal operation to care for the psychiatric patients from all regions. This is not acceptable for the following reasons:

(a) All the problems of distance from home locality, opportunity for re-establishment and follow-up care that have been experienced with one centralized women's prison would be repeated under this arrangement.

(b) Ease of transfer for short term diagnostic investigation would be difficult and expensive.

(c) The opportunity to develop a comprehensive, high quality, well staffed psychiatric service for all institutions in a region would be diminished without a professional base in the region.

(d) The encouragement of training and fostering of research potential by universities affiliated with regional centres would be limited to only one affiliation in one area.

(e) The general trend to reduce the size of maximum security institutions to a humane scale, would be contravened by one federal hospital of adequate size.

(*) Vide Section 2.

Alternative 3: Another approach would be to undertake treatment programs under non-medical aegis for those with abnormal psychological disorders. This approach, often referred to as the "social-deviance model" in contradistinction to the "medical model" has its advocates. However:

(a) When this approach is attempted it is often necessary to involve the psychiatrist to provide at least a "legal cover" for what, under the provincial medical acts, would otherwise be the treatment of diagnosable illnesses by unlicenced practitioners of healing.

(b) Even if the legal barriers were overcome, certain of the conditions to be diagnosed or treated require skills, techniques and remedies only within the competence of a physician. This would apply to all acute, sub-acute and chronic cases and to a percentage of the cases in the Special Program Group.

(c) Where this approach has been tried it has been observed that two systems emerge both of which suffer from lack of close collaboration and unproductive rivalry.

Alternative 4: The possibility of utilizing Federal Medical Services such as Department of Veterans Affairs or Department of National Defence Hospitals to care for Federal Prisoners has been advanced.

While this may be practical in some situations for the short term care of physical ailments, it offers little for the care of psychiatrically ill prisoners, for these reasons:

(a) There are only two D.V.A. hospitals, one at London, Ontario and the other at Ste. Anne de Bellevue in Quebec that have psychiatric facilities of any size. Both are a considerable distance from any federal penitentiary and neither offers the professional staff nor the physical facilities to care for prisoners.

(b) The policy, already partly implemented, of the Department of Veterans Affairs, is to turn its hospitals over to provincial responsibility often as university hospitals and to divest themselves of direct responsibility for their operation.

(c) Discussion with appropriate Department of Veterans Affairs officials has indicated that there would be strong objection to any sharing arrangements by their patients and staff and also from the Canadian Legion. Like the Provincial Mental Hospitals they are not geared to cope with mentally ill federal penitentiary inmates.

Part II – SUGGESTED COURSE OF ACTION

Having found no suitable alternative by which psychiatric services might be provided, the Board considered the steps required to achieve a workable solution in the Canadian Penitentiary Service:

(1) The first requirement is an overall plan accepted by the Federal Government, a plan which can provide the guidelines, goals and authoritative support for regional programs.

(2) An essential requirement is for the Government to make a commitment to improve the quality of psychiatric services, and for the Canadian Penitentiary Service administration to be provided with resources and personnel beyond the present minimal and, at times, dangerously inadequate level.

(3) A third requirement is an administrative organization that permits medical direction of the programs, with clear cut lines of professional communication and responsibility at all levels.

(4) The fourth step is a unification of psychiatric services throughout the federal correctional systems particularly in respect to the penitentiary and parole services; and, when appropriate, linking these with provincial mental health services, e.g., Quebec and Prairie Provinces.

(5) The Board has been occupied in its early deliberations with the location, size, organization and relationship of one aspect of the total program, namely "psychiatric centres". It is convinced that such centres are essential to provide the following services:—

(a) as an active treatment psychiatric centre for the acute and sub-acute mentally ill and emotionally disturbed individuals;

(b) as an observation centre for the study in depth of inmates in whose offences psychological elements have played an obvious role, for whom future rehabilitation will pivot around determination of the inmate's mental condition, its treatment and prognosis;

(c) as a centre for the care of the chronically mentally ill inmate whose offence is embedded in his distorted mental processes. Such inmates may or may not have few chances for eventual release but must be afforded every opportunity for treatment, both on a humane and on a scientific basis;

(d) as a centre for the care and treatment of those emotially disturbed individual whose crime, in effect, is a symptom of his basic condition, with its criminal implications of secondary importance. Such a centre would direct its energies towards a positive rehabilitative program with emphasis on active psychiatric treatment;

(e) as a centre where the dynamics of personality and crime might be studied in respect to prevention, causation, treatment and rehabilitation;

(f) as a centre for training personnel in the diagnosis, treatment and research techniques of the anti-social personality. Psychiatric training at the post-graduate and under-graduate levels would be of great value, as herein are combined the intricacies of law, medicine and sociology which would be of value to other disciplines, such as, criminologists and students of law and psychiatry.

(g) As well as these direct functions, the centres will assist in providing a base for professional growth, advancement of knowledge, and maintenance of the standard of care in the areas of reception and classification, ambulatory consultation and care in the general prison population, consultation, advice, after care and follow-up arrangements with the National Parole Service.

The Board is opposed to any one architecturally uniform, equal sized, administratively identical institution being duplicated across the country.

(6) Staffing: — To provide adequate psychiatric services to the various groups of patients that have been identified as needing care, continuing outpatient services to all regional institutions, the necessary consulting and advisory services to the administrations, and to engage in training and investigation, will require a staffing standard comparable to that established for any acute psychiatric hospital offering community services.

The Board recommends the patient/staff ratios for various classifications of professional and therapeutic personnel in accordance with Appendix 9.

Not only is it important to have an adequate number of staff but they must be kept continuously abreast of their fields of competence, or receive special training appropriate to their work on appointment.

(7) Affiliation with Universities – The individual reports submitted by the regional representatives of the Board indicate a general willingness on the part of the relevant universities to enter into negotiations with regard to affiliation with the appropriate centres. The early establishment of Liaison Committees to initiate discussions with regard to affiliation, is recommended by the Advisory Board. Full affiliation, would, of course, be dependent on the centres being appropriately staffed and funded to support research and teaching and on treatment programs meeting required universities standards.

Psychiatric Centres with the proposed affiliation with relevant universities offer a unique opportunity for the development of new and improved methods of care and treatment for those individuals who are presently the responsibility of the Canadian Penitentiary Service and National Parole Board. There is a great and urgent need for this type of research not only in Canada but on an international basis. While the Board intends to devote itself to determining relevant research needs it is obvious that, as well as general problems in this field applicable on an international basis, there are specific Canadian problems requiring research, for example, the psychological problems of the Indian/Metis population of the Prairie Institutions. It is not anticipated that the Department of the Solicitor General should support all research carried out in these Centres, for example, if genetic studies were being considered, gunding might be obtained from the Medical Research Council. It is considered that several other relevant agencies could assist in specific projects.

Part III – GENERAL RECOMMENDATIONS

In the light of the above considerations, the following recommendations are submitted:

(A) With regard to Regional Psychiatric Centres, generally, the Advisory Board recommends:

(1) That there be five Regional Psychiatric Centres in the Canadian Penitentiary Service;

(2) That there should be diversity of arrangements in the planning of penitentiary psychiatric centres and the provision of psychiatric services in different regions, recognizing the variety of needs, programs and facilities that are operative in the five main regions of Canada;

(3) That a unified psychiatric service be established in each region under the professional direction of a regional psychiatrist who would assign the professional staff to provide the range of services required on a priority basis. This would provide:

(a) better professional liaison, collaboration and consultation,

(b) opportunities for diversity of practice, continuing care throughout all phases of illness (initial consultation, inpatient treatment and after - care), and

(c) coverage of separate institutions during vacation, illness, absences at medical meetings, etc.

(4) That a formal approach be made as soon as possible to those universities with which it is hoped the Regional Psychiatric Centres might be affiliated. It should be recognized that, nowadays, a meaningful association with a university usually requires a formal agreement spelling out basic ground rules, some form of checks and balances with regard to the academic aspects, mutual obligations, etc. Such negotiations should be opened, and if

possible, agreements approved, before the appointment of Medical Directors, since this is a crucial event which initiates many of the processes of program development, staff appointments, etc.

(5) That in order to attract and keep professional staff and to facilitate university affiliation the centre must be located within convenient distances of large urban and/or university centres;

(6) That the Medical Director should be appointed as soon as possible, preferably during the planning stages and in any case at least one year before the opening of the Regional Psychiatric Centre;

(7) That before a Regional Psychiatric Centre is opened there must be an adequate number of professional staff available and that plans should have been made for the training of ancillary staff;

(8) That the operating cost of psychiatric care provided in the Canadian Penitentiary Service should be commensurate with those costs that reflect an adequate and contemporary standard of psychiatric care;

(9) That the functions of research and teaching within the penitentiary psychiatric centres are essential to successful operation of these centres and that budgetary provision for these centres be adequate for this purpose.

(B) With regard to Staff Requirement and Development, the Advisory Board recommends:

(10) That professional staff should annually attend one major professional meeting, plus one meeting of special concern to the forensic behavioural scientist;

(11) That in order to foster the continuing professional development of its professional personnel, and to encourage the selection of a career in the service, this Board recommends the institution of a program to provide study leave at regular intervals;

(12) That financial support for training in psychiatry be provided by the Department of the Solicitor General for those near the end of or at the completion of specialty training, in order that they may concentrate on advanced training in penology and forensic psychiatry. This funding could be provided through at least two mechanisms:

(a) The awarding of one year fellowships after a minimum of three years of post-graduate specialty training; or,

(b) Permitting the first year of regular full-time appointment to the Medical Service of the Penitentiary Service to be devoted to special accredited training.

In order to meet the present commitments for the number of professionals required for psychiatric services, this program should be initiated as soon as possible.

(C) With regard to National Parole Board and National Parole Service, The Advisory Board Recommends:

(13) That there should be early joint planning and consensual agreement on treatment goals and requirements to be fulfilled, established between the psychiatric staff and National Parole Service officers in order that release of inmates will ensue at a meaningful time, if the conditions of parole are met;

(14) That the need for a study of the provision of adequate psychiatric services on release be recognized, and that this study be undertaken immediately by the Advisory Board in conjunction with the National Parole Board;

(15) That psychiatric staffing levels be set, taking into account the work load necessary to fulfil the National Parole Board's requirements for the preparation of psychiatric reports, consultation with Parole Board panels, National Parole Service officers and participation in follow-up.

Part IV – REGIONAL DISCUSSION AND RECOMMENDATIONS

In the outline of Method of Work in Section I of the report it was pointed out that individual members of the Board were delegated to represent the appropriate regions in Canada and to consult with provincial Government Departments, universities and professional associations (See Appendices 1 to 5 for lists of those consulted).

(A) Atlantic Region

NEW BRUNSWICK

There was agreement by all concerned that the logical place for the Centre was Halifax in collaboration with Dalhousie University. The staff at Dorchester Penitentiary stressed the urgent need for such an institution and that present facilities for looking after mentally ill people are neither fair to the patients nor to the staff. The Attorney General's Department and the Health Department indicated their desire to collaborate in this type of unit. Their requirements are reflected in the number of beds indicated for the psychiatric centre for this region. They stressed the need for close inter-relationship with the Provincial Mental Health Service outpatient facilities, day hospitals, etc.

NOVA SCOTIA

A conservative estimate from discussion with those consulted indicates that Nova Scotia would require 15 beds in addition to those individuals from Nova Scotia currently in Dorchester Penitentiary.

PRINCE EDWARD ISLAND

It is apparent from our study that the Province is definitely interested in having this type of institution established and estimate they would have four to five patients there at any one time.

NEWFOUNDLAND

The Province of Newfoundland might occupy two or three beds in the proposed psychiatric centre but apart from that appears prepared to look after all other types of patients.

In view of the above, the Board recommends:

(16) That a federally constructed Psychiatric Centre be established at Halifax, for joint federal-provincial use;

(17) That this Centre provide accommodation of approximately 100 beds for:

- 60 penitentiary patients
- 20 provincial correctional patients
- 20 provincial mental-health patients;

(18) That affiliation with Dalhousie University be explored with a view to the early appointment of the Medical Director.

(B) Quebec Region:

The situation in Quebec differs quite radically from that existing in all other regions in that the Philippe Pinel Institute is prepared to accept a considerable number of our inmates for treatment. This matter was discussed by Dr. Béliveau with Mr. Claude Forget, Assistant Deputy Minister of the Finance Division of the Department of Social Affairs and a per diem rate of $67 was suggested. It was also suggested that the Canadian Penitentiary Service guarantee that a minimum number of 30 federal-patients be under treatment at the Institut Philippe Pinel at any one time. In view of the statistical data from the Quebec Region, it is obvious that, in fact, a much larger number of patients would be under treatment at the institution and that this number might well be as high as 100. It was felt that the Canadian Penitentiary Service should continue to treat acute cases and the construction of a 48-bed unit for this purpose was recommended. The three Universities are interested in affiliation with such a Centre if it meets the accreditation and affiliation requirements.

In view of the above, the Board recommends:

(19) That approval in principle be given for the construction of a federal psychiatric centre of 48 beds, to be located in as close proximity as possible to a large urban and university centre, for penitentiary patients requiring acute short-term psychiatric care, and with associated appropriate ambulatory care facilities;

(20) That, as the Institut Pinel is offering a range of treatment programs which meet the needs of penitentiary patients, and as the per diem cost charged by Institut Pinel is consistent with costs prevailing elsewhere, use be made of the facilities available in the Institut Pinel for penitentiary patients of the Quebec Region other than those provided for in Recommendation 19 above;

(21) That the Quebec psychiatric service be organized in such a way as to provide close association of the federal and provincial psychiatric services in institutions specializing in the treatment of psychiatric and/or behaviour disorders and with the respective universities in developing a common program of teaching and research in forensic psychiatry.

(C) Ontario Region:

All of those consulted considered that the numbers involved, the size, staffing and location made it preferable – even mandatory – that the Penitentiary Service provided within its own resources for the psychiatric diagnosis, care and treatment of all its charges within the Province of Ontario.

All organizations agreed that since the largest concentration of the inmate population was in the Kingston area that this was the most logical site for a federal psychiatric facility. This conclusion was enhanced by the proximity to Queen's University. The university representative is of the opinion that such a centre, provided it is adequately supported to render a high standard of teaching and research, could be affiliated by a suitable agreement with the university for clinical training of many university students in psychiatry, psychology, sociology, nursing, law, etc.

The Ontario Ministry of Correctional Services indicated that there was a significant need for additional psychiatric resources for inmates currently within the Ontario system. The categories most likely to be admitted would include inadequate personalities, mental defectives, chronic psychotics and the like. The most probable mode of participation by the province would be on a per diem basis.

In view of the above, the Board recommands:

(22) That approval in principle be obtained for construction of the Psychiatric Centre in the Kingston area, with accommodation for 144 beds, to fulfil the needs of the following programs of treatment for penitentiary patients;

(i) for acute and sub-acute psychiatrically ill patients;

(ii) continuing treatment for patients with serious chronic psychiatric disablements which render them unable to reside within general penitentiary population;

(iii) therapy for patients with character disorders, for sexual offenders, alcoholics, drug addicts;

(iv) for clinical investigation;

(23) That approval in principle be obtained as early as possible with a view to activating the Liaison Committee with Queen's University and the appointment of a Medical Director.

(D) Prairie Region:

MANITOBA

There was general agreement in Manitoba that mental hospitals were not equipped to deal with the problems presented by non-psychotic patients such as aggressive or schizoid psychopaths who were dangerous and there was general agreement that a centrally located institution for the treatment of those offenders would be highly desirable.

The Acting Head of the Department of Psychiatry at the University of Manitoba saw this facility as useful for teaching and for research into the causes of crime and into better treatment methods for those offenders with personality disorders.

The Manitoba Psychiatric Association expressed the opinion that mental hospitals were not capable of treating the agressive personality disorder types of patients because of their ability to manipulate staff and most particularly their ability to manipulate other patients.

ALBERTA

In Alberta, as in Manitoba, there was a general consensus that those patients with severe personality disorders created a great problem in provincial jails, that treatment methods for them were inadequate and that a special centralized unit wherein treatment methods for this group of offender could be developed, would be highly desirable. If such an institution is established, the University Department of Psychiatry would like to intergrate it into their residency training program and would like to be involved in research projects.

SASKATCHEWAN

The Provincial Mental Hospitals in Saskatchewan find great difficulty in providing the sort of security required for patients sent to them by the courts or by the Lieutenant-Governor's order. It would be the desire of mental health and correctional authorities in Saskatchewan to refer to the proposed regional treatment centre many, but not all, of their patients from the Provincial correctional Institutions. The Province has expressed its desire to participate in the centre with regard to some of its patients.

The University of Saskatchewan, Saskatoon Campus, is keenly interested in the development of the treatment centre and it would appear that they would be quite

prepared to give joint appointments to the staff at the treatment centre in appropriate university departments where the university had been consulted with respect to the appointments.

Great possibilities are seen for research not only by the Department of Psychiatry but also by the Departments of Psychology, Sociology, Criminology and Law. Such a centre could be integrated into the residency training program of the Department of Psychiatry.

In view of the above, the Board Recommends:

(24) That a federal-provincial Psychiatric Centre for the three prairie provinces be constructed and operated at Saskatoon by the federal government;

(25) That this Centre provide accommodation of 150 beds for:

86 penitentiary patients

64 mental-health and correctional patients from the three Provinces;

(26) That services be provided by this Centre to fulfil the needs of the following programs:—

(i) reception, and remand for psychiatric assessment (for the Province of Saskatchewan only);

(ii) for acute and sub-acute psychiatrically ill patients;

(iii) continuing treatment for patients with serious chronic psychiatric disablements which render them unable to reside within the general population of prisons or mental-health hospitals;

(iv) therapy for patients with character disorders, for sexual offenders, alcoholics, drug addicts;

(v) for clinical investigation;

(27) That approval in principle to construct this Centre be obtained as early as possible with a view to activating a Liaison Committee with the University of Saskatchewan and to the appointment of the Medical Director.

As with the Atlantic Region, the problems of multiple jurisdiction, population density and travel distances pose special constraints on the Prairies.

(E) British Columbia Region:

It is fairly obvious that the place of psychiatry within the British Columbia Penitentiary is that of a token situation. The psychiatrists having been given no authority are regarded by those within and outside the administration as powerless. Their very powerlessness to effect change or introduce new patterns of care within the administrative structure invites a lack of respect towards them and hence reinforces the token situation. With respect to the services at the Riverside Unit, a unit within the Provincial Mental Health Services that holds approximately 288 patients, there are serious deficiencies both in physical plant, in professional staff and in patterns of care.

The program needs for this region indicate a number of small and flexible psychiatric units designed for specific purposes with planned functional programs for the following categories:—

(a) Acute and Sub-acute psychiatrically ill patients.

(b) Those patients who are mentally retarded or chronically organic — that is, suffering from epilepsy or conditions where brain syndromes are involved, and including chronic schizophrenics who require continuing treatment programs.

(c) Patients in need of special programs such as severe personality disorders, drug addicts, alcoholics, sex offenders, and Dangerous Sexual Offenders.

In view of the above, the Board Recommends:

(28) That the Matsqui Female Unit, including the Pilot Treatment Unit and hospital, be developed as a psychiatric centre for approximately 138 patients;

(29) That, as soon as approval in principle is obtained, the Liaison Committee with University of British Columbia be activated, and that steps be taken for the appointment of Medical Director;

(30) That, immediately following the approval in principle, appropriate arrangements be made for the staffing of all proposed units.

Part V – FUTURE DEVELOPMENTS: – CASE LOADS

The anticipated case loads for the next decade are based upon certain assumptions:

(1) that the psychiatrically ill and significantly disabled will be designated as falling under the administrative direction of the regional psychiatric service and will be treated by Canadian Penitentiary Service psychiatric services;

(2) that special investigation or treatment programs for specifically identified inmates will be on a trial basis and will not necessarily be provided for all inmates with similar personality defects or having committed similar offences. This refers to personality disorders, sexual offenders, etc.

Three possible long-term shifts in policy which could affect the previous recommendations are: (These shifts would have little impact in the Atlantic and Prairie Provinces for the proposal is to provide secure facilities to care for all the dangerous, mentally disordered no matter what their jurisdictional status).

(a) Provision for transfer of increased proportion of the less dangerous mentally ill for short or long-term (including up to termination of sentence) care in provincial psychiatric hospitals.

(b) Changes in the volume of the correctional population in custody, including earlier parole, transfer of certain persons presently undergoing sentence in provincial correctional institutions. Then the recommendations of thi sReport would have to be amended accordingly. Moreover the surveys conducted in connection with the Canadian Committee on Corrections do not suggest that Canadian pyschiatric hospitals will look favorably on "hospital orders" and particularly "restriction orders" on release from hospital, as a form of sentence. Experience with the treatment of offenders in Mental Hospitals under the British Mental Health Act 1959 has not been satisfactory, according to Rollin(*). Changes in treatment attitudes and physical environment make any form of security repugnant to staff and difficult to achieve.

(c) Developments of and possible conflicts between the present and future constitutional, administrative and legal distinctions for the care of dangerously mentally ill offenders and the dangerous persons and their clinical and "social defense" needs of society in providing safe and therapeutic environments for these groups.

The variable arrangements being proposed will provide facilities across Canada which can be constitutionally and administratively reclassified and altered if and as the

(*) H.R. Rollin – The Mentally Abnormal Offender and Law. Rergamon Press. London 1969

jurisdiction, functions and mandates shift and change between federal and provincial governments and between mental health and correction services within the Provinces. However, no immediate, relevant constitutional amendment is contemplated in the foreseeable future.

Three of the present proposals, are based on the present count of the dangerously mentally ill or disordered requiring care and would not be materially changed in total by jurisdictional shifts. The Quebec plan at this point proposes maximum melding of provincial services and federal services with acute patients that could be assigned to other jurisdictional authorities should the roles and assignments shift.

The two distinctively federal prison hospitals being proposed at this time, namely at Kingston, Ont., and Abbotsford, B.C. are recommended partly because there are no adequate regional provincial facilities for the care of these inmates, even if administrative arrangements were concluded.

If and when a second maximum security hospital for Ontario in addition to Penetanguishene is required, it would be most logically located in the region of Kingston. Thus if in future years it is constitutionally decided that the ill or disabled offender should be in the custody of provincial health authority then the institution could be transferred without changing the need for such a facility for the Ontario regional population.

Similarly in British Columbia there is no reason to believe that the present provincial health facilities for closed, high custody units are adequate and if the care of additional mentally ill offenders were legally required sometime in the future, under provincial auspices, then appropriate transfer of the proposed British Columbia federal facility would be an economical solution.

Such alternative use should be taken into account since, even without the constitutional complexities of the division of corrections between provincial and federal in Canada, those countries with only one government authority have had shifts of assignment between Departments of Health and Corrections of its Special Prison Hospital, such as Broadmoor.

As clinicians, the Advisory Board can only advise that the total patient accommodation required in each region for the care, clinical investigation, observation and treatments with the present population trends, has been ascertained accordingly.

SECTION VI

Evaluation of Psychiatric Services

The direction to the Advisory Board to consider the evaluation of effectiveness (and cost benefit) of various psychiatric programs opens a matter of wide implication and great importance. Different criteria are appropriate in order to evaluate the effectiveness of psychiatric services in their multiple roles.

(1) As clinical consultants to medical, classification, parole services, etc., effectiveness would be assessed on the promptness, comprehensiveness, comprehensibility and professional judgement and relevance reflected in reports required.

(2) As treaters of illness, the effectiveness of the treatment programs could only be assessed on comparison of outcome of therapeutic programs for various identifiable conditions – e.g., agitated depressions, acute anxiety states, delirium, in comparison with other treatment regimes.

There are increasing peer appraisal techniques to assess comparable quality of care, including duration of treatment, reduction of "target" symptoms, ratio of recurrences, psychological measurements, suicide.

There are additional economic benefits that could be calculated in determining cost benefit, including earlier release to the community. Contemporary economists recognize now that benefits to the patient himself are separate from but paramount to other benefits – benefits to prison administration, to other persons, to society at large.

The assessment of cost benefits must consider both the cost in dollar terms and benefits obtained primarily by the patient himself.

(3) As advisors to classification officers and as "operators" of special programs for the chronically disabled inmate their effectiveness can only be assessed by establishing cost savings based on removal from the usual prison programs of those who are unlikely to benefit from these programs because of their disablement. Such cost benefits might be:

(a) Improvement in function and general well-being of patients;

(b) A decrease in the cost of the regular program by virtue of their reduced demands for special handling, special protection or individualized supervision within the inmate population and prevention of undesirable incidents;

(c) Change in staff morale and staff attitude resulting hopefully in decreased turnover.

(d) Comparison by behavioral scales symptom reduction.

(4) As clinical investigators, attempting to explain and determine bio-psychosocial correlations, and to assess factors contributing to behavioral modification – effectiveness can only be assessed in the scientific forum. As scientists – evaluation rests on the scientific "respectability", adequacy and merit of published results. No other criteria can be substituted for independent professional review with critique.

As a national priority – unless Canada is to sit back and wait for other nations to expend their resources in this search (to our country's eventual benefit), then some policy must be established as to our proper duty and share in this international endeavour. There are direct operational benefits that should accrue from sound research findings as well as the social benefits of operating in a self-critical appraising setting.

(5) The greatest problems arise in the area of evaluation of the effectiveness of special psychiatric programs aimed at correction of specific offenders or the modification of behaviour in such a way as to reduce recidivism, criminality, dangerousness, or socially unacceptable conduct.

The first implication is that psychiatric programs can only be evaluated against a background of overall evaluation of the total federal corrections programs and their various differences. In other words the answer to the question "Is it effective?" addressed to any specific correctional or therapeutic program, must be "compared to what"?

There have been a few outcome studies of particular programs or particular institutions. The best and most consistent of these have been from the California Correctional Authority(*). Others from Clinton(**) Patuxent, Grendon Underwood (***) have been of a preliminary nature and often represent relatively short term "follow-ups".

We know, unfortunately, that studies of outcome of special centres have been permitted publication in the open criminological literature only when they support a specific program. Whether "negative" studies that have resulted enjoy equal publicity is suspect. Any skewing in this regard makes objective assessment impossible. Ward(****) points out the economic, political and social repercussions of such studies in these words:—

> "In short, correctional agencies face an inherent conflict between the pressures to develop new programs and empirically validate them and the requirement that these same agencies fulfil the public mandate to proceed efficiently and effectively with the business of rehabilitation. This conflict should provide a good part of the answer to the question of why correctional evaluation is a minority characteristic in American penology. Correctional administrators are aware of the fiscal and political implications latent in every research proposal that has to do with the assessment of correctional outcome. Limitations placed on the number of evaluative studies do not necessarily reflect a lack of appreciation for scientific studies of organizational effectiveness, but may represent an awareness of the vagaries of legislative appropriations and political realities".

In general, reviews of evaluation studies point to the methodological shortcomings of the majority such as those pointed out by Bailey (*****).

The problems of adequate evaluation of correctional programs are dealt with in detail in a recent bulletin of the Massachusetts Correctional Association, and these

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(*) L.I. Kim and T.L. Clanon *Psychiatric Services Integrated into the California Correction System.* Int. Journal of Off. Ther. 15, 169, 1971.

(**) L. Fink, W.N. Derby and J. Martin *Psychiatry's New Role in Corrections.* American J. Psych. 126, 542, 1969.

(***) H.P. Tallinton *The Psychological Treatment of Abnormal Offenders.* Prison Services J. 5, 19, 1966.

(****) David Ward *Evaluations of Correctional Treatment: Some implications of Negative Findings.* Proceedings of First National Symposium on Law Enforcement Science and Technology, 1967.

(*****) Bailey, W.C. Correctional Outcome: An Evaluation of 100 Reports. Jour. of Crim. Law, Criminology and Police Science, Vol. 57, 153, 1966.

problems range from the lack of financial appropriations to staff concern when evaluation is applied:

> ". . . . Any department of corrections has a basic obligation to seek actively for resources to carry out systematic and competent assessment of program effectiveness. . ."

and further:

> ". . . . Evaluative research . . . will inevitably pose problems for administrative, treatment, and security personnel; and they will create problems for the research staff. . ."(*)

The most important contribution of this publication however, is in detailing the present state of knowledge and the necessary procedures in furthering evaluative research in corrections, including the techniques for cost benefit analysis.

RESEARCH

The Psychiatric Advisory Board must urge the development of an adequate competent research establishment including appropriate relationships between the penitentiary service, parole service and provincial correction service.

Such mission or applied research to ensure quality control of the goals of the undertaking is not an insignificant cost item. What percentage of the total cost of federal corrections including both the penitentiary service and parole service operations should be identified for this operational research activity needs decision. The Senate Science Policy Reports suggest Research and Development costs as optimally in the range of 2-3% of total costs of any operation. Only a portion of this can be assigned to quality control evaluations since funds must be preserved for innovative programs themselves in the research and development area.

Without a firm commitment, adequate resources, a fully aligned program between the Canadian Penitentiary Service and the Parole Service, as well as meaningful collaboration with provincial correction services, Statistics Canada and the Fingerprint Section of the Royal Canadian Mounted Police, it is unlikely that any corrections program, including psychiatric services, can be meaningfully evaluated or cost benefits derived.

This does not necessarily imply the development of a large intramural research establishment but rather the framework for intensified collaboration with the university research establishment as represented by the growing centres of criminology across the country and with the Canadian Criminology and Corrections Association.

A strong advisory correction research council to the Solicitor General with provincial representations, on lines similar to this Psychiatric Advisory Board could provide the needed leadership. Specific, needed studies could be assigned and financed both intramurally and on contractual grants to research centres.

Moreover we urge that it be clearly accepted that Canada is prepared to subject all our correctional undertakings to the most rigid evaluation and set an example to other jurisdictions, in openly making known all our findings to those most concerned.

We have dwelt more fully on this area than may seem appropriate by our terms of reference but can foresee no other means by which the requirement, that we subject our programs to adequate evaluation, can be properly carried out.

(*)Correctional Administrator's Guide to the Evaluation of Correctional Programs", in Correctional Research Bulletin, No. 21, 1971, Boston, Mass. U.S.A.

The Board recommends ongoing development with departmental economic advisors of cost/effectiveness and cost/benefit assessment of these programs when they become effective, as well as the more traditional scientific measures of outcome.

In view of the above, the Board Recommends:

(31) That steps be taken immediately to develop techniques for the evaluation of the effectiveness of psychiatric programs in penitentiaries.

SUMMARY

The Advisory Board of Psychiatric Consultants, appointed by the Solicitor General, has developed its report through consultations by its Regional Representatives with officials of relevant provincial governments, universities and professional association in all regions of Canada.

The report reviews the objectives of psychiatric services in any correctional system, and it gives the historical background of psychiatric services in the Canadian Penitentiary Service. It formulates the requirements for providing adequate psychiatric services in the specifically Canadian setting; wherein various alternatives are considered and numerous recommendations are made as to how such services might be effected. Finally, the report deals with the problem of evaluating the effectiveness of psychiatric services in terms of cost benefits; this matter will also be the subject of a complementary report rendered by consulting economists appointed by the Solicitor General to collaborate with the Advisory Board of Psychiatric Consultants.

RESUMÉ OF RECOMMENDATIONS

1. That there be five Regional Psychiatric Centres in the Canadian Penitentiary Service.

2. That there should be diversity of arrangements in the planning of penitentiary psychiatric centres and the provision of psychiatric services in different regions, recognizing the variety of needs, programs and facilities that are operative in the five main regions of Canada.

3. That a unified psychiatric service be established in each region under the professional direction of a regional psychiatrist who would assign the professional staff to provide the range of services required on a priority basis. This would provide:

   (a) better professional liaison, collaboration and consultation,

   (b) opportunities for diversity of practice,

   (c) continuing care throughout all phases of illness (initial consultation, inpatient treatment and after care), and

   (d) coverage of separate institutions during vacation, illness, absences at medical meetings, etc.

4. That a formal approach be made as soon as possible to those Universities with which it is hoped the Regional Psychiatric Centres might be affiliated. It should be recognized that, nowadays, a meaningful association with a university usually requires a formal agreement spelling out basic ground

rules, some form of checks and balances with regard to the academic aspects, mutual obligations etc. Such negotiations should be opened, and if possible, agreements approved, before the appointment of Medical Directors, since this is a crucial event which initiates many of the processes of program development, staff appointments, etc.

5. That in order to attract and keep professional staff and to faciliate university affiliation the centre must be located within convenient distances of large urban and/or university centres.

6. That the Medical Director should be appointed as soon as possible, preferably during the planning stages and in any case at least one year before the opening of the Regional Psychiatric Centre.

7. That before a Regional Psychiatric Centre is opened there must be an adequate number of professional staff available and that plans should have been made for the training of ancillary staff.

8. That the operating cost of psychiatric care provided in the Canadian Penitentiary Service should be commensurate with those costs that reflect an adequate and contemporary standard of psychiatric care.

9. That the functions of research and teaching within the penitentiary psychiatric centres are essential to successful operation of these centres and that budgetery provision for these centres be adequate for this purpose.

10. That professional staff should annually attend one major professional meeting, plus one meeting of special concern to forensic psychiatrists.

11. That in order to foster the continuing professional development of its psychiatric personnel, and to encourage the selection of a career in the service, this Board recommends the institution of a program to provide study leave at regular intervals.

12. That financial support for training in psychiatry be provided by the Department of the Solicitor General for those near the end, or at the completion of specialty training, in order that they may concentrate on advanced training in penology and forensic psychiatry. Thus funding could be provided through at least two mechanisms:

    (a) The awarding of one year fellowships after a minimum of three years of post-graduate specialty training; or,

    (b) Permitting the first year of regular full-time appointment to the Medical Service of the Penitentiary Service to be devoped to special accredited training.

    In order to meet the present commitments for the number of professionals required for psychiatric services, this program should be initiated as soon as possible.

13. That there should be early joint planning and consensual agreement on treatment goals and requirements to be fulfilled, established between the psychiatric staff and National Parole Service Officers in order that release will ensue at a meaningful time, if the conditions of parole are met.

14. That the need for a study of the provision of adequate psychiatric services on release be recognized, and that this study be undertaken immediately by the Advisory Board in conjunction with the National Parole Board.

15. That psychiatric staffing levels be set, taking into account the work load necessary to fulfill the National Parole Board's requirements for the preparation of psychiatric reports, consultation with Parole Board Panels, National Parole Service Officers and participation in follow-up.

16. That a federally constructed Psychiatric Centre (to serve the Atlantic Region) be established at Halifax, N.S. for joint federal-provincial use.

17. That this Centre provide accommodation of approximately 100 beds for:

    60 penitentiary patients
    20 provincial correctional patients
    20 provincial mental-health patients.

18. That affiliation with Dalhousie University be explored with a view to the early appointment of the Medical Director.

19. That approval in principle be given for the construction of a federal psychiatric centre of 48 beds (for the Quebec Region), to be located in as close proximity as possible to a large urban and university centre, for penitentiary patients requiring acute short-term psychiatric care, and with associated appropriate ambulatory care facilities.

20. That, having satisfied itself that the Institut Pinel is offering a range of treatment programs which meet the needs of penitentiary patients, and that the per diem cost charged by Institut Pinel is consistent with costs prevailing elsewhere, use be made of the facilities available in the Institut Pinel for penitentiary patients of the Quebec Region other than those provided for in Recommendation 19 above.

21. That the Quebec psychiatric service be organized in such a way as to provide close association of the federal and provincial psychiatric services in institutions specializing in the treatment of psychiatric and/or behaviour disorders and with the respective universities in developing a common program of teaching and research in forensic psychiatry.

22. That approval in principle be obtained for construction of the Psychiatric Centre at the Kingston area (to serve the Ontario Region) with accommodation for 144 beds, to fulfil the needs of the following programs of treatment for penitentiary patients:

    (i) for acute and sub-acute psychiatrically ill patients;

    (ii) continuing treatment for patients with serious chronic psychiatric disablements which render them unable to reside within general penitentiary population;

    (iii) therapy for patients with character disorders, for sexual offenders, alcoholics, drug addicts;

    (iv) for clinical investigation.

23. That approval in principle be obtained as early as possible with a view to activating the Liaison Committee with Queen's University and the appointment of a Medical Director.

24. That a federal-provincial Psychiatric Centre for the three prairie provinces be constructed and operated at Saskatoon by the Federal Government.

25. That this Centre provide accommodation of 150 beds for:

    86 penitentiary patients
    64 mental-health and correctional patients from the three Provinces.

26. That services be provided by this Centre to fulfil the needs of the following programs:—

    (i) reception, and remand for psychiatric assessment (for the Province of Saskatchewan only);

    (ii) for acute and sub-acute psychiatrically ill patients;

    (iii) continuing treatment for patients with serious chronic psychiatric disablements which render them unable to reside within the general population of prisons or mental-health hospitals;

    (iv) therapy for patients with character disorders, for sexual offenders, alcoholics, drug addicts;

    (v) for clinical investigation.

27. That approval in principle to construct this Centre be obtained as early as possible with a view to activating a Liaison Committee with the University of Saskatchewan and to the appointment of the Medical Director.

28. That the Matsqui Female Unit, including the Pilot Treatment Unit and hospital, be developed as a psychiatric centre (for the British Columbia Region), for approximately 138 patients.

29. That, as soon as approval in principle is obtained, the Liaison Committee with University of British Columbia be activated, and that steps be taken for the appointment of the Medical Director.

30. That, immediately allowing the approval in principle, appropriate arrangements be made for the staffing of all proposed units.

31. That steps be taken immediately to develop techniques for the evaluation of the effectiveness of psychiatric programs in penitentiaries.

IMPLEMENTATION

The report submitted to the Solicitor General by the Advisory Board of Psychiatric Consultants proposes a program for the development of psychiatric services in the Canadian Penitentiary Service which is based on extensive regional consultations.

Dependent upon appropriate policy decisions and approvals in principle, much further work could then be undertaken by the Advisory Board. The Board could continue as the national coordinating group and immediately proceed to the following tasks, viz:

(a) Evaluating and advising on plans and programs submitted by the Regional Committees mentioned hereunder,

(b) Initiating further discussions with the National Parole Board concerning the provision of psychiatric services to meet their needs,

(c) Evolving further evaluative techniques in conjunction with the Research Division of the Department of the Solicitor General,

(d) Reviewing and approving research projects pertinent to psychiatric services.

The Regional Representatives of the Advisory Board could act as chairmen of appropriate regional committees which could refine the existing data in relation to regional needs, and consult further with appropriate regional bodies regarding plans and programs.

CONSULTATION in the ATLANTIC REGION

The Regional Representative of the Advisory Board of Psychiatric Consultants has effected consultations with the following persons:

NEW BRUNSWICK:

Dr. Richard Short,
Director of Mental Health for the Province of New Brunswick.

Mr. John Warner,
Senior Solicitor in the Attorney General's Department.

Dr. Robert Gregory,
former administrator of the Provincial Hospital Lancaster, and the psychiatrist who does most of the court work in New Brunswick.

Dr. I. Kapkin,
President of the New Brunswick Psychiatric Association and Dr. Gregory's successor as the Administrator of the Provincial Hospital in Lancaster.

Hon. Paul Creaghan,
Minister of Health for the Province of New Brunswick.

Doctors P. Michel and M. Wright,
Institutional psychiatrists, Dorchester Penitentiary.

Mr. U. Bélanger,
Director, Dorchester Penitentiary.

Relevant members of the staff at Dorchester Penitentiary, including the prison psychologist, a padre and classification officers.

NOVA SCOTIA:

Dr. H. Poulos,
Clinical Director of Nova Scotia Hospital.

Dr. R. Townsend,
Administrator of Mental Health Services in Nova Scotia.

Mr. Innis MacLeod,
Deputy Attorney General.

Mr. R. Anderson,
Senior Solicitor in the Department of the Attorney General with a particular interest in the criminal side of the Attorney General's work.

Dr. Edmund Ryan,
and relevant staff at Springhill Institution.

NEWFOUNDLAND:

Dr. C. A. Pottle,
Director of Mental Health for Newfoundland.

Dr. Fraser Walsh,
Medical Director of the Hospital for Nervous and Mental Diseases, St. John's.

Professor John Hoenig,
Head of the Department of Psychiatry of Memorial University.

The Right Honourable Lord Taylor of Harlowe,
President of Memorial University.

Mr. E. Cummings, Administrator,
Hospital for Nervous and Mental Diseases, St. John's.

Dr. Ian Rusted,
Dean of the Faculty of Medicine, Memorial University.

Mr. Victor MacArthy,
Senior Solicitor in the Attorney General's Department.

PRINCE EDWARD ISLAND:

Due to the holding of a Federal-Provincial Conference it was not feasible for the Regional Representative to visit Prince Edward Island. Data was obtained from Dr. Owen Custis, Deputy Minister of Health.

CONSULTATION in the PROVINCE OF QUEBEC

The Regional Representative of the Advisory Board of Psychiatric Consultants has effected consultations with the following persons:

Dr. Maurice Gauthier,
General Director of Provincial Correctional Institutions.

Dr. Jacques Brunet,
Deputy Minister of the Department of Social Affairs.

The Executive Committee of the Quebec Psychiatric Association.

Mr. Claude Forget,
Assistant Deputy Minister of the Finance Division, Department of Social Affairs.

Mr. Roger Larose,
Vice-rector of University of Montreal.

Dr. Pierre Bois,
Dean of the Faculty of Medicine of University of Montreal.

Dr. Gérard Beaudoin,
Director of the Department of Psychiatry, University of Montreal.

Dr. Pierre Martel,
Director of the Department of Psychiatry, University of Sherbrooke, delegated by Dr. Jean de L. Migneault, Dean of Medicine of that University.

Dr. Bruno M. Cormier,
Director of McGill Forensic Clinic, delegated by Dr. Maurice MacGregor, Dean of Faculty of Medicine of McGill University.

CONSULTATION in the PROVINCE OF ONTARIO

A meeting was held in Toronto in September 1971 by Dr. F.C.R. Chalke at which the following were in attendance.

Dr. W. Henderson,
Director of Mental Health Services for the Province of Ontario.

Dr. A. Ives,
Mental Health Division,
Ontario Provincial Department of Health.

Dr. E. Turner,
Chairman of the Committee for Forensic Services,
Ontario Psychiatric Association.

Professor T. Boag,
Head of the Department of Psychiatry, Queen's University, Kingston, representing the Principal John Deutsch.

Dr. C. K. McKnight,
Chief of Forensic Service,
The Clarke Institute, Toronto.

On November 8, 1971 a meeting was held by Dr. C.K. McKnight with

Mr. L. R. Hackl,
Deputy Minister,
Ontario Department of Correctional Services.

CONSULTATION in the PRAIRIE REGION

The Regional Representative of the Advisory Board of Psychiatric Consultants has effected consultations with the following persons:

WINNIPEG:

Dr. Harry Prosen,
Acting Head, Department of Psychiatry,
College of Medicine, University of Manitoba.

Dr. R. Tavener,
Assistant Deputy Minister, Mental Health,
Assistant Deputy Minister of Corrections.

Dr. E. Johnson,
Director of Forensic Services.

Dr. W. Lambert,
Review Board.

BRANDON:

Dr. J. F. Alexander, Chairman,
Manitoba Psychiatric Association.

Dr. Tyler,
Department of Psychology, Brandon University.

EDMONTON:

Dr. F. Brent,
Advisor in legal medicine to the Attorney General.

Mr. S.A. Friedman
Deputy Attorney General.

Dr. W. G. Dewhurst,
Acting Head, Department of Psychiatry,
University of Alberta.

Dr. William Bobey, President,
Alberta Psychiatric Association.

Mr. B. Rawson,
Deputy Minister of Planning.

Mr. Casson,
Attorney General's Department.

Dr. F. J. Edwards,
Division of Mental Health Services.

Dr. C. P. Hellon,
Mental Health Advisor.

Mr. F. Oswin,
Director of Correctional Institutions.

Principal Robert Begg,
University of Saskatchewan,
Saskatoon Campus.

Dr. J. D. Earp,
Associate Professor, Department of Psychiatry,
University of Alberta.

Dr. W. B. Dorran,
Resident in Charge of Forensic Unit,
Oliver Mental Hospital.

Dr. A. D. MacPherson,
Forensic Consultant.

Mr. B. Barker,
Professor of Law, University of Alberta.

Judge N. G. Hewitt,
Family Court, Edmonton.

Miss Russell,
Solicitor for the Family Court, Edmonton.

CALGARY:

Dr. K. I. Pearce,
Professor of Psychiatry.

Mr. Milton Harrandence, lawyer.

SASKATCHEWAN:

Dr. Ian McDonald,
Head, Department of Psychiatry,
University of Saskatchewan,
Saskatoon Campus.

Executive,
Saskatchewan Psychiatric Association.

Professor Roger Carter,
Dean of Law,
University of Saskatchewan,
Saskatoon Campus.

Dr. Colin M. Smith,
Executive Director,
Psychiatric Services Branch,
Department of Public Health,
Regina.

D. T. Thompson,
Chief of Corrections.

CONSULTATION in the PROVINCE OF BRITISH COLUMBIA

The Regional Representative of the Advisory Board of Psychiatric Consultants has effected consultations with the following persons:

Hon. Ralph Loffmark,
Minister of Health for the Province of British Columbia.

Dr. H. W. Bridge, Coordinator of Adult Psychiatry,
Mental Health Services.

Dr. W. V. Goresky, Chairman,
Patterns of Practice Committee,
Section of Psychiatry.

Chief of Police,
Vancouver.

Commanding Officer,
"E" Division, RCMP.

Mr. S. Rocksborough-Smith,
Director of Corrections.

Administrators, within the Penitentiary Service, psychiatrists, politicians and those involved in social rehabilitation work concerning inmates.

NUMBER AND CATEGORIES OF PENITENTIARY INMATES REQUIRING PSYCHIATRIC CARE AND TREATMENT

The following data was obtained in response to a questionnaire circulated to institutional Directors and Psychiatrists in October 1971.

CATEGORIES OF PATIENTS	REGION					
	ATLANTIC	QUEBEC	ONTARIO	PRAIRIE	B.C.	TOTAL
Acute cases	91	85	68	65	149	458
Sub-acute cases	36	30	152	23	62	303
Chronic cases	included in 36 above	157	163	32	20	372
TOTAL	127	272	383	120	231	1,133

The total given under acute cases represents the number of these cases occurring in the calendar year 1970. As each case, by definition, requires treatment for a period of less than two months, an approximate expression of the number of acute cases occurring at any one time would be 76. Accordingly, the amended overall total number of cases in above categories should read:

acute	76
sub-acute	303
chronic	372
Total	751

This represents approximately 10.2 per cent of the penitentiary population as of November 2, 1971.

Data was also obtained with regard to categories of inmates for whom Special Programs might be organized. These included personality disorders, dangerous sexual offenders, other sexual offenders, alcoholics and drug addicts; and 1175 inmates were identified in these categories.

COMPARISON OF COSTS OF SELECTED PSYCHIATRIC FACILITIES

a) British Columbia Psychiatric Centre with Provincial Mental Hospitals in Ontario and Quebec

The Department of Financial Services of the Canadian Penitentiary Service conducted a cost comparison of the Regional Psychiatric Centre with two Quebec institutions, The Clarke Institute and four other institutions in Ontario.

TABLE A: COST PER PATIENT DAY

	Pen. Service	North-Eastern	Owen Sound	Goderich	Pinel	Penetang-uishene	Clarke Inst.	St. Jean de Dieu
Operating Costs								
Personnel	40.73	35.09	33.67	33.32	44.66	20.74	49.00	14.26
Other Operating Expenses	6.36	7.55	5.22	4.94	9.55	3.33	13.58	2.76
	47.09	42.64	38.89	38.26	54.21	24.07	62.58	17.02

For various reasons the costs for the Mental Health Centre, Penetanguishene, the Clarke Institute and St. Jean de Dieu are not comparable. St. Jean de Dieu, for example, is a 3,745 bed hospital treating medical, psychiatric and handicapped patients. At the Mental Health Centre the program embraces both medical and psychiatric patients as well as a category known as residential patients. At the Clarke Institute the program is again quite different from that planned by us. It is a training hospital for both doctors and nurses. It engages in large research operations and has a children's Psychiatric section. The data obtained from these hospitals did not permit a segregation of costs by type of program and comparability was not possible.

In comparing the above figures it should be noted that $7.00 of the total per diem cost shown for the Regional Psychiatric Centre is occasioned by the necessity to provide adequate security. The only other hospital to which this applies is the Philippe Pinel Institute.

b) Psychiatric Centre (British Columbia complete establishment) with a Maximum Security Institution

TABLE B	PSYCHIATRIC CENTRE	MAXIMUM SECURITY INSTITUTION
Operating Costs		Weighted average cost of Maximum Security Institution
Personnel	40.73	
Other Operating Expenses	6.36	
	47.09	25.00

c) Psychiatric Centre (British Columbia Interim Establishment) with a Maximum Security Institution

TABLE C:	PSYCHIATRIC CENTRE	MAXIMUM SECURITY INSTITUTION
Operating Costs		
Personnel	31.34	Weighted average cost of Maximum Security Institution
Other Operating Expenses	8.45	
	39.79	25.00

In considering the 'per diem' cost for the Regional Psychiatric Centre, it must be borne in mind that the establishment of this centre would, apart from providing urgently needed psychiatric services, also provide the following additional benefits:

(a) the proposed staffing of the centre will enable the Canadian Penitentiary Service to provide professional psychiatric services to inmates in all penitentiaries (i.e. not only those transferred to the Centre), including outpatients and consultation services;

(b) by the removal of certain patients from the general penitentiary population, reduce their disruptive influence upon institutional life, and help to improve the rate of success of the rehabilitation programs applicable in the general inmate population in existing institutions;

(c) enable the Department of the Solicitor General to meet the National Parole Board's unanimous expression of concern about the Canadian Penitentiary Service current lack of adequate diagnostic and treatment services;

(d) enable the Canadian Penitentiary Service to train key staff for the new programs under the concept of 'living units';

(e) enable the Department of the Solicitor General to engage in medical and correctional research, more extensively and hopefully with much greater benefits than it is possible at present.

These additional benefits were discussed with the Consulting Economists (on January 20-22, 1972); and the economists concur that such factors would be included in the cost-benefit analysis which they are conducting and which no doubt will be included in their own report to the Solicitor General.

ABSTRACTS FROM, AND RECOMMENDATIONS MADE by the FAUTEUX REPORT and REPORT OF THE ROYAL COMMISSION ON SEXUAL PSYCHOPATHS

The Fauteux Report, 1956:

> ". . . . . If rehabilitative treatment is to be made available for any considerable number of inmates, special facilities must be provided for the treatment of special cases: alcoholics, drug addicts, sex offenders, psychotics . . . . The problem of sex offenders is primarily a medical problem . . . . it is obvious that effective treatment can only be discovered if such persons are made the subjects of special study. We feel that sex offenders should be removed from the normal prison population and that intensified research on the problem should be carried out. . . ."
>
> (page 48)
>
> ". . . . . The problem of psychotic offenders similarly requires special consideration . . . We must record our views that no modern prison system can operate effectively without psychiatric service on a much more extensive basis than now exists . . . . This, again, is a medical problem, requiring facilities, staff and research . . . . . ."
>
> (page 48)
>
> ". . . . . Considering these four major groups of inmates (alcoholics, drug addicts, sex offenders, psychotics), therefore, the Committee RECOMMENDS the establishment of appropriate prison-medical centres, functionally designed and staffed for the purposes indicated. Such institutions must provide suitable security and custodial arrangements. But they should have, as far as possible, the atmosphere of hospitals. If effective treatment is to be provided in such cases, it must be in an institution in which the ordinary prison routines will be considerably relaxed in order that individual treatment may be given without in any way undermining security requirements. . . . ."

The Fauteux Committee supported the recommendations of the Royal Commission of 1938 (the Archambault Report) regarding the "incorrigible inmates", but classified them as psychopathic persons:

> ". . . . . At the present time such prisoners form part of the general prison population. Many of them are serious custodial risks and their presence in the general prison population necessitates the imposition of special custodial arrangements which greatly handicap a normal program of rehabilitation and correction. The Archambault Report recommended the establishment of special institutions for the "incorrigibles". . . . We cannot RECOMMEND too strongly that special facilities for the segregation of such persons should be made available, perhaps in one institution, where all the other facilities of the institution could be made available for the treatment of this special group . . . . . ."
>
> (page 48)

The Royal Commission on Sexual Psychopaths, 1958:

Regarding the lack of special facilities:

> ". . . . . These prisoners (criminal sex offenders under preventive detention) appear to be treated in the same manner as any other prisoner. Although the provisions of the Criminal Code governing this class of offenders contemplate that they will receive special psychiatric

treatment, facilities for such treatment are NOT available. Dr. O'Connor, a psychiatrist on the staff of Kingston Penitentiary, when giving evidence before us emphasized the inadequacy of the psychiatric services in that institution.

He is the only psychiatrist provided to render professional psychiatric service to a population of 800 inmates. He gives five half-days a week to these services. He said the psychiatric ward of nine beds is used for those who are acutely ill . . . . ."

(page 91)

". . . . . Regarding the examination and treatment of those sentenced as criminal sexual psychopaths, Dr. O'Connor said:

> They could be seen at very close intervals if one wished to arrange to do so. To put it very bluntly, I am not making any effort now to treat anyone so convicted in Kingston Penitentiary, because the attendant difficulties to therapy are so great as to make it very questionable if I am not wasting my time . . . Seeing them once a month is useless. They would require a very intensive therapy, a long-term intensive therapy, and in the face of the present situation that is impossible . . . . ."

Dr. O'Connor further said that the methods of treatment that he suggested could not be carried out in a prison. His recommendation was that a Treatment Centre should be set apart from the regular prison, with reference back to the Courts for release. His suggestion has the support of many other witnesses . . . . ."

(page 92)

The Royal Commission questioned also Dr. Louis Bourgoin, psychiatrist at the St. Michel Archange Hospital in Quebec City. He gave testimony as follows:

". . . . .If for the last 50 years psychiatry made giant strides of progress in the field of mental illness proper, it must also be recognized that its knowledge concerning sexual anomalies has but little evolved and the purely therapeutic measures are . . . practical non-existent. This deplorable state of affairs is partly due to the fact that medical science, for various reasons, was never free to explore this field, and mostly to the too little known fact that there exist some illnesses for which medical science can yet do nothing . . . . ."

Nothwithstanding the evidence heard, the Royal Commission took more positive attitude towards the problem:

". . . . . We think that a more positive attitude is of great importance, and a positive attitude demands more than mere custodial care for the sexual psychopath. We are convinced that with custodial care must go definite progressive methods of the application of all known helpful means of treatment, and the development of new means.

These are medical problems and they must be left to the medical profession . . . . ."

(page 96)

The Royal Commission 1958 advocated research to be undertaken:

". . . . . In addition to community clinics, an organized scientific study of the cases of all sexual offenders committed to serve indeterminate sentence should be undertaken, and if possible extended to all sex offenders serving sentences in penitentiaries, with a view of developing improved methods of treatment of those committed to prison, whether for an indeterminate or definite period . . . . ."

(page 121)

CONCLUSION No. 16 expressed by the Royal Commission:

> "There is urgent need in Canada for research in all aspects of sexual deviation, with a view to development of means of correction and prevention".
>
> (page 124)

Among RECOMMENDATIONS made by the Royal Commission, are these:

> "No. 9 . . . THAT special provision be made in the penitentiary system for the custody, control and treatment of every sex offender undergoing preventive detention".
>
> (page 129)
>
> "No. 15 . . . THAT the Government of Canada, through special grants to universities and otherwise, develop special research schemes to determine the causes of sexual abnormality and improved methods of treatment".
>
> "No. 16 . . . THAT special clinics be set up in cooperation with the courts and penal institutions, to which a person found guilty of any sex offence may be required to report for study and treatment".
>
> (page 130)

STAFFING REQUIREMENT
for the
PENITENTIARY REGIONAL PSYCHIATRIC CENTRES
proposed by the
ADVISORY BOARD OF PSYCHIATRIC CONSULTANTS, 1972

The Board considered an appropriate staffing pattern based on their extensive knowledge of operating various types of psychiatric facilities and on the work done by the Committee on Standards and Staffing set up, in 1968, by the Provincial Mental Health Services, Province of Saskatchewan and the Board recommends the following:

Administration — One psychiatrist as Medical Director for each of the five penitentiary regions.

Psychiatric Care: Clinical and Nursing personnel in relation to the volume of patients, as follows:

(a) For In-patients Care:

(i) One psychiatrist for 20 patients, exclusive of functions of training and research.

(ii) One professional non-medical therapist for 15 patients (or: one psychologist for 30 patients and one social worker for 30 patients).

(iii) 80 nursing personnel for 100 patients.

(b) For Ambulatory Care:

One psychiatrist for 60 ambulatory outpatients.

(c) Supporting Services:

Psychometrist, pharmacists, chaplains, teachers, occupational instructors, recreational supervisors, and the usual administrative, clerical and domestic — services staff — to be ascertained by appropriate standards.

While a staffing pattern based on the above ratios must eventually be achieved it should be realized that this is an optimal standard and that several factors, for example, difficulty in recruiting and the general lack of availability of such professional staffing in Canada, will make such a staffing pattern a goal to work toward rather than an immediate achievement. However, this should not delay the decision to implement the provision of urgently needed psychiatric services as recommended by the Board. In most instances, it will be necessary to open these Centres with a limited number of patients related to the number of professional staff which it has been possible to recruit. The Centres can be brought to full occupancy as the number of professional staff increases. In relation to the ratio quoted under ambulatory care it should be indicated that this ratio is a national average based on a wide variety of cases. Prior to any implementation of this, considerable work would have to be done to ascertain patient hours of contact and any institutional region would have to justify such a request on this basis.

As the Female Satellite at Matsqui is a known quantity, that is, its architectural and potential capacity are known, a staffing establishment has been developed for a proposed psychiatric centre in that institution.

SUMMARY OF POSITIONS BY CATEGORY
PSYCHIATRIC CENTRE

Support Category		
Stenographers	6	
Clerical	8	
Total Support		14
Administration Category		
Admin. & Supply Officer	1	1
Operational Category		
Laundry	2	
Storeman	1	
Instructors	4	
Correctional Officers	40	
Kitchen	3	
Total Operational		50
Professional Category		
Psychiatrist	4	
Medical Director	1	
Medical Officer (Contract)	1	
Dental Officer (Contract)	1	
Director of Research	1	
Research Assistants	2	
Technician	1	
Social Workers	4	
Psychologists	4	
Occupational Therapists	4	
Nurses	92	
Psychiatric Residents	2	
Teachers	2	
Total Professional		119
GRAND TOTAL		184

However, in view of the factors mentioned above, namely, difficulty in recruiting staff, ideal staffing pattern being a long term goal, etc., a feasible transitional establishment (based on British Columbia Psychiatric Centre) would be as follows:

Support Category	18
Security	40
Professional	90
Total	148