

FORENSIC CLINICS:

A Comparative Study

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THE ROLE OF FORENSIC CLINICS
IN THE ADMINISTRATION OF CRIMINAL JUSTICE

CHAPTER I

CHANGING ATTITUDES TO THE CRIMINAL OFFENDER

BY

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ABSTRACT

The main purpose of this study is to examine the uses of forensic clinics in the administration of criminal justice as devices for the identification, diagnosis of treatment of psychiatric disorder in convicted offenders. A subsidiary aim of the study is to assess the feasibility of the establishment of such a facility in British Columbia.

The thesis is introduced by an account of those changes in the criminal law which have resulted in its ceasing to be a simple instrument of deterrence and in increasing attention being paid to the principles of extenuation and rehabilitation. An attempt is then made to survey and evaluate recently published data on the prevalence and distribution of mental disorders in criminal populations, and the conclusion is drawn that approximately one fifth of all persons convicted of an indictable offence in typical North American jurisdictions are suffering from psychiatric problems serious enough to play an important part in their prospects of rehabilitation, even if those problems have had little direct causal significance in the commission of the original crimes. This is followed by a survey of the statutory auspices, administrative structures, clinical programs and financial bases of eight established forensic clinics, seven in the United States and one in Canada. This survey, together with material drawn from the published literature of criminology and public administration, serves as the basis of an attempt to formulate the requirements of an "ideal" forensic clinic. The model synthesized in this fashion is then applied to the local Provincial situation and a series of recommendations are made concerning the procedures to be followed and the principles to be observed in establishing a forensic clinic in British Columbia.

The principal desiderata of effectiveness for a forensic clinic identified in the thesis are that:

- (1) in regard to both staffing arrangements and the character of its program, the clinic should be inter-disciplinary rather than purely psychiatric;
- (2) it should be expected to give purpose and precision to existing correctional facilities in the penal system, and not to compensate for the fact that none actually exist;
- (3) it should have no fixed commitment to dealing exclusively with one particular class of offenders (such as sexual offenders), but should hold itself ready to deal with any offenders whose problems and whose treatment it can competently advise on;
- (4) its workloads should never be such as to reduce its activities to routine levels or raise the dangers of perfunctoriness;
- (5) it must be sensitive to the working problems and needs of the courts of criminal justice but independent of direct control by the judiciary.

CHAPTER I

CHANGING ATTITUDES TO THE CRIMINAL OFFENDER

The Jurisprudential Aspect of Corrections

Crime has been a feature of the life of all nations in every period of history. But the acts that have been defined as "criminal," and the patterns of response that have been made to those acts, have both exhibited the greatest variety of form. Many of these variations can be convincingly related to the character of the society in which they occur. Indeed, as Friedman says:

The state of the criminal law continues to be - as it should be - a decisive reflection of the social consciousness of society. What kind of conduct an organized community considers, at a given time, sufficiently condemnable to impose official sanction, impairing the life, liberty or property of the offender, is a barometer of the moral and social thinking of the community.¹

Not only our view of the criminal and his criminality, but also our notions of the entailed 'wrong against society,' change from age to age. Thus the introduction of new methods of dealing with the offender may be construed as evidence of - almost as an affirmation of - novel perceptions of the significance of law-breaking. Forensic clinics, therefore, as a recently conceived and still far from widespread agency of criminal justice, are expressive of important shifts in contemporary penal philosophy and practice. No account of what forensic clinics are and of what they are intended to accomplish can be considered complete unless it includes reference to these changes and to the manner in which they constitute the case for such clinics. We shall deal, first, therefore, with the evidence for and the direction of the changes.

¹ Friedman, W., Law in a Changing Society; Stevens and Sons Ltd.; London; 1959, p. 165.

Brutality Loses its Respectability

Even a casually brief survey of the history of the methods used to deal with lawbreakers would show that punishments are no longer as harsh as they were. Numerous examples are available to point the contrast. Thus, up till 1827 in England all felonies, right down to the theft of anything above the value of a shilling, were punishable by death.¹ In Bavaria, the draft code of 1810 contained the extraordinary provision that the death penalty had to be commuted to life imprisonment if a murderer had committed the crime in order to be so punished. Apparently at that time conditions in and out of prison were so bad that many people sought death - having recourse to the capital penalty because of the Christian proscription of suicide.² Although this strange piece of legislation hints at a situation of bizarre abnormality, the penal systems of all the western nations during the nineteenth century were uniformly oppressive and often savage.³ It was only at the end of the nineteenth century that a more liberal and humane attitude began to appear. The reform movements of this period in England, Germany and France were motivated by the belief that

... Man can influence man's development, just as he can dominate nature, and that crime can be combatted by proper social policy.⁴

This era marked the decline of the harsh and brutal treatment of the offender; or at any rate, it marked the decline of the respectability of such treatment.

Law Used as a Tool of Repression Declines

The fact that contemporary codes of punishment are less emphati-

1 Birkett, Lord, (Ed), The Newgate Calendar; The Folio Society; London; 1960.

2 Mannheim, Hermann, The Dilemma of Penal Reform; George Allen and Unwin Ltd.; 40 Museum Street, London; 1939, p. 25.

3 Rusche, Georg, and Kirchheimer, Otto, Punishment and the Social Structure; Morningside Heights; Columbia University Press; New York, 1939, p. 113.

4 Rusche and Kirchheimer, op cit, p. 140.

cally concerned with deterrence and repression than were those of even fifty years ago is almost certainly attributable to changes in the climate of social life which had their origins outside the sphere of the criminal law itself. Thus the principle of less eligibility was introduced to prison administration in the early nineteenth century to discourage the poor (generally considered the criminal class) from resorting to crime as an ingenious way of putting themselves beyond the reach of the iron law of wages.

If even the conditions of the non-criminal population should be made less eligible than that of the worst paid laborer, surely the criminal should make no claim for better treatment than the poor.¹

Prison conditions as a result were deplorable, and ...

... anyone who found himself in jail because of some trifling offense ran the risk of paying for his error with lifelong illness or even death.²

A systematic effort was being made during this period to repress the criminal activity of the lower classes. The height of pauperism was reached in England between 1780 and 1830,³ as a result of the profound economic changes brought about by the industrial revolution. Crime flourished on a scale and with a ferocity that brought the country to the edge of a class war that in fact never quite broke out. A fear-driven brutality invaded the administration of the criminal law, and it was hoarsely asserted that "... the axe, the whip, and starvation ought to be reintroduced in order to root out the criminals."⁴ It was only when the more violent stages of early industrialization had given way to the comparatively stable (if still bleak) conditions of an established industrial system that the criminal law itself ceased to be an instrument of coercion. As Mannheim says:

1 Mannheim, op cit, p. 57.

2 Rusche, and Kirchheimer, op cit, p. 105.

3 Ibid, p. 95.

4 Ibid, pp. 95-97.

... One can summarize the progress of civilization as mounting from the standpoint of deterrence, pure and simple, to that of reformation, restricted first by the principle of less eligibility, and later by non-superiority.¹

The economic abundance and political stability of the modern social democracies create the grounds for an equitable and cool tempered approach to the criminal law which was scarcely possible in an era of conflict and hardship.

The Nature of the Offence Becomes Related to its Punishment

There is an observable trend, too, to differentiate crimes on the basis of the threat they pose to the social order, in contrast to the practice of earlier ages when crimes of all kinds were treated in very much the same way. It is plausible to suppose that as punishment ceases to be a tool used by one group to suppress another, the possibility of differentiating between crimes is enlarged. In a society where the majority are ruled by a powerful and autocratic minority, every crime may be seen as a threat to the uneasy equilibrium of the relations between the two groups. The earlier example cited, that of the practise of punishing nearly all felonies by death, is an extreme case of this former lack of differentiation. The originator of the first systematic attempts to relate the gravity of the offence to the nature of the punishment was Cesare Beccaria. In his celebrated essay Crime and Punishment, published in 1764, he condemned the uncertainty of punishment and the arbitrariness of the courts and argued that there should be a legally recognized graduation of punishment, its severity being scaled in accordance with the gravity of the offence.² Beccaria's theories rapidly

1 Mannheim, op cit, p. 58. Non-superiority ... the condition of a criminal when he has paid for his crime should be at least not superior to that of the lowest classes of the non-criminal population. p. 75.

2 Rusche, and Kirchheimer, op cit, pp. 74-76, also see, Monachesi, Elio, "Cesare Beccaria," Pioneers in Criminology; Stevens and Sons Ltd.; London; 1960.

won adherents in most parts of the civilized world.¹

The penal reform movement which sprang from these beginnings undertook to state standards (sometimes very naive ones) by which to measure the seriousness of the crime.² Its main concern was with limiting the power of the state to punish by creating fixed rules and subjecting the authorities to firm constitutional controls.³ This insistence on relating the severity of the crime to its punishment validly persists, and is embedded deeply in popular notions of justice. It asserts certain fundamental claims of the convicted person against arbitrary treatment by the state and the courts. The sentencing authority is in no way exempted from the limitations upon its decisions implied in this principle even when it is "treatment" that is being considered.

... It would be intolerable if for example, for a petty offense a very heavy sentence might be imposed, only because the mental condition of the offender might require prolonged treatment.⁴

The Equation of Crime with Sin Disappears

Along with this responsiveness to distinctions concerning the gravity of the offence, there has also been an increasingly explicit tendency to differentiate between those acts which are liable to formal sanction and control and those which are not. Again, the kind of conduct which is 'forbidden' will often reflect the type of society doing the forbidding. Hence in a small, culturally homogeneous community where verbal censure is an important mechanism of social control, "random" gossiping may be a crime to be punished through public action; whereas under the typical conditions of urban life, it may be considered a personal frailty of the individual,

1 Ibid, p. 73.

2 For a discussion of one such standard see Geis, Gilbert, "Jeremy Bentham," Pioneers in Criminology, Stevens and Sons Ltd.; 1960, pp. 51-67.

3 Rusche, and Kirchheimer, op cit, p. 73.

4 Mannheim, op cit, p. 209.

and perhaps even joked about.¹ Mannheim refers to fundamental distinctions of this kind when he says:

It was regarded as the achievement of the fifteenth and sixteenth centuries to have established a clear cut demarcation between the realm of morals and that of politics, and as an equally great success of the eighteenth and nineteenth centuries to have made the criminal law independent of morality.²

Hobbes, in the Leviathan, similarly differentiates between crime and sin.

A crime is a sinne, consisting in the committing (by deed or word) of that which the law forbiddeth, or the omission where it hath commanded. So that every crime is a sinne, but not every sinne a crime.³

We now recognize that some things that are punishable by the law are not morally culpable, while other things which might be considered morally culpable are not punished by the law.⁴ In fact statute law is not generally seen nowadays as being essentially concerned with the moral law, but as a means for protecting private interests and public goods that must be compatible with the moral law. Although adultery remains a nominal crime in many jurisdictions, it is seldom actually treated as such; and it is almost inconceivable that the tribunals of the individual conscience, the pulpit and the courts should be joined in this and similar matters as they were in Hawthorne's The Scarlet Letter.⁵

The 'Rule of Law' Becomes the Ideal

The judicial process has itself undergone drastic changes in the

1 Scoldes in the sixteenth century Englande (and elsewhere) were punished by public 'dunking'. (Reported in Spargo, John W., Juridical Folklore in England; Duke University Press; Durham, N.C., 1944.)

2 Mannheim, op cit, p. 20.

3 Rusche, and Kirchheimer, op cit p. 73 - reprinted from Hobbes, Leviathan, the edition of 1651 (Oxford 1909), p. 224.

4 Moberly, Sir Walter, Responsibility, The Riddell Memorial Lectures - 21st series; Oxford University Press; London, New York, Toronto; 1951. An example of the first would be exceeding the speed limit, which represents a danger to society. No thought, however, no matter how evil, has ever been punishable by the law until it was expressed in overt action.

5 Though it occasionally happens even now - as some contend the trial of Stephen Ward reveals. Moreover, although there is almost general agreement about the principle, there is far less unanimity about what questions come

past few centuries. Prior to the Enlightenment, criminal law administration was generally capricious and inefficient, and seldom free of political interference. The cry of the early reformers like Beccaria was for "Public trials, free choice of lawyers, trial by jury, suppression of torture, clearly defined laws of evidence, protection against illegal imprisonment - these demands in the name of humanity and human progress were to benefit all classes alike."¹ The effects of these new procedures differed widely among classes, and to some extent still do, but they were the basis of our present judicial system. It is upon this foundation that the changes in the criminal law have been introduced. The transformation of the criminal law and court procedures was slow; it was not, for example, until 1898 in England that the prisoner was allowed to give evidence on his own behalf, and wives of husbands became competent witnesses for the defence.²

The Criminal is an Individual

We are also increasingly aware of the fact that criminals are not all cast in the same mould. With this recognition there has been a trend in the law toward greater specialization, especially with regard to the disposition of those convicted of crime. The introduction of probation and parole were among the early modifications tending toward the individualization of treatment. Juvenile courts and the indeterminate sentence are others.³

We are more concerned with the complexities in the causation of

written in the terms of the principle. For example, most people (but not all) would acknowledge that homosexuality ought not to be the concern of the criminal law if it offers no risk of public harm; but there is much controversy as to whether homosexuality offers these risks.

1 Rusche, and Kirchheimer, op cit, p. 76.

2 Birkett, op cit - Introduction.

3 Overholser, Winfred, "Psychiatry's Contribution to Criminal Law and Procedures", Psychiatric Quarterly Supplement, Vol. 30-31, 1956-57.

crime to-day than were the reformers of the eighteenth and early nineteenth centuries. They tended to see crime and punishment, and thus the offender, in the abstract. We no longer fully believe that the lawbreaker is a free moral agent, wilfully desiring to do evil rather than good, or actuated by simple hedonistic drives.¹ Thus we cannot feel with the Quakers of the late eighteenth century and early nineteenth, that "religion is the only and sufficient basis of education," nor do we expect measures like solitary confinement to "have the effect of turning the sinner back to God." (Quite the contrary, we now see solitary confinement as an agonizing psychological punishment.)² The "positivist" influences of the early and mid-nineteenth century emphasized the factual, scientific study of the individual offender. The aims of men like Lombroso, Ferri, and others of this school, were to study the nature and origins of crime and to provide, by social and legal means, the various remedies required to control the causes that produced it.³ Thus although, in large measure, substantive criminal law does still rest on the ancient (and valid) principle which postulates the criminal as a free moral agent,⁴ criminology has become a sort of quasi-science, and we are moving towards a system of criminal justice which integrally comprises the notions of rehabilitation through diagnosis, treatment and prevention.⁵

1 Ellington, John R., "Training for Delinquency Control at the University of Minnesota", National Probation and Parole Journal; Vol. 12, no. 2, April 1956.

2 Rusche, and Kirchheimer, op cit, p. 127.

3 For a discussion of the "positivists" see Mannheim, Hermann (ed), Pioneers in Criminology; Stevens and Sons Ltd.; London; 1960.

4 Ellington, op cit.

5 We are well aware - not to say depressingly aware - of the endless philosophical problems associated with (perhaps inescapably entailed in) the paradoxical relations between the notion of "free will" and the assumptions underlying the "scientific" or "causal" study of human behaviour. It is within neither our competence nor our terms of reference to plunge into these problems. We will content ourselves here with the dogmatic assertion that there is no contradiction of an immobilizing kind in the practical, decision-making contexts, between a man being responsible for what he did (and thus

In the preceding pages some of the changes which have occurred in recent history in dealing with the criminal have been pointed out. We shall now consider, in greater detail, some of the causes lying behind these changes. The discussion will be limited to several strategically important factors, namely: the general elevation in our respect for life, the changes in class relations in modern states, the move away from the belief that all crimes are alike in challenging a fixed, inviolable and 'sacred' order, the development of a highly differentiated and morally "pluralistic" society, and, of course, the influence of the social and behavioural sciences. We shall also consider the problem of developing a coherent and socially efficient method of dealing with criminal behaviour to replace the repressive and heavy-handed methods that have now been repudiated.

Modern Life Permits Greater Respect for Human Life

It is evident that our age does avow a greater respect for human life than did earlier generations. We would not, for example, tolerate the mutilations and tortures to which criminals were formerly subjected. And whereas at one time death was the common penalty for most crimes, and while at the same time, the determination of guilt or innocence was an essentially perfunctory business, one of the most damning criticisms of capital punishment (where it remains at all) to-day is "the danger of irretrievable error."¹ Collectively, we are taking more and more responsibility for providing the basic necessities of a 'good life' to every citizen. Government is assuming functions which were once thought to be the responsibility of the individual, the family, the church or the local community. The technologies of production and of medicine have introduced standards of abundance, comfort, good health and longevity which would have been scarcely conceivable to our for-

a "free agent") and his having had reasons for what he did that may require a kind of scientific study before they can be precisely known (and thus provide the data necessary for rational sentencing policies.)

1 Friedman, W., op cit., p. 179.

bears; and thus we have lost the case-hardened familiarity with, and even indifference to, poverty, disease and sudden death which were to be found as recently as in Victorian times.¹

Relations between Social Classes Change

As we have observed in passing already, the relations between social classes have changed radically over the last two hundred years. We may refer, for example, to the eighteenth century's struggle against feudal privilege and the arbitrariness of monarchy. It was characteristic that Beccaria and the other early criminologists² were concerned with fixing rules which would limit the power of the state.

The existent criminal law of the eighteenth century was, in general, repressive, uncertain, and barbaric. Its administration permitted and encouraged incredibly arbitrary and abusive practises. The agents of the criminal law, were allowed tremendous latitude in dealing with persons accused and convicted of crime, and corruption was rampant ... The sentences imposed were arbitrary, inconsistent and depended upon the status and power of the convicted.³

This was the hey-day of social contract theories, with their unprecedentedly forthright claims that sovereignty resided in the people, and that the law applied equally to all citizens.⁴ Of course, there was considerable room for differences of opinion as to who was properly to be regarded as a citizen, and as a result, the new judicial procedures were often least available to the very classes that were most palpably in need of them.⁵

1 The atom bomb and the concentration camp are sometimes cited as the only two examples of an alleged decrease of concern for human life and suffering in the twentieth century. It is not a simple matter to deal with this kind of objection to the claims being made here; and the least we should do is be on our guard against facile generalizations. War and totalitarian politics certainly constitute a major exception to the trends we are asserting to be observable. The reader will, perhaps, allow that in the ordinary affairs of civil life people are more squeamish about the sight of a maimed beggar, a beaten child, or surgery without the benefit of anaesthetic.

2 Beccaria would not have understood the meaning of this term, 'criminologist'; see Mannheim, Hermann, (ed), "Introduction", Pioneers in Criminology; Stevens and Sons Ltd.; London; 1960.

3 Ibid, pp. 38-39.

4 Ibid

5 Rusche, and Kirchheimer, op cit, p. 76.

The rhetoric of equality was chiefly used to legitimate an extension of privilege from the aristocracy to the bourgeoisie. In the nineteenth century, however, the locus of the struggle had shifted, and the rights secured a generation earlier by the new entrepreneurial classes now became the goals of political and economic action among the labouring masses of industry.¹ With the growth of labour unions, the expansion of suffrage, and minimum wage laws, this previously powerless group gradually gained some measure of control over its destiny. Little by little, equal access to the courts and equal status before the law - hitherto among the perquisites of wealth - became part of the customary rights of all citizens; though only those who regularly mistake words for deeds will suppose that the job is more than half done.

The Natural Law Doctrine Loses Validity

The growth of the modern, "pluralistic" state, composed as it is of people of every possible ethnic and racial background, characterized by political systems designed explicitly to accommodate dissent, with long-standing traditions of religious tolerance, has made it difficult to approach the tasks of making and administering the law in the expectation that it will stand for all time and apply to every phase of conduct. The notion that there are certain universal and unvarying principles from which the content of the laws can be prescriptively inferred will carry little conviction in a society where diversity and change are the experience of daily life. The ancient doctrine of natural law has survived only in esoteric settings. As Kelsen has said:

This doctrine maintains that there exists a perfectly just regulation of human relations, emanating from nature - nature in general; or human nature, the nature of man being endowed with reason. In an examination of nature we find the immanent

¹ Rose, Gordon, The Struggle for Penal Reform; The Library of Criminology; London; Stevens and Sons; Chicago; Quadrangle Books Inc.; 1961, p. 14.

norms prescribing the just conduct of men. If nature is supposed to be created by God, the norms immanent in nature, natural laws, are the expression of the will of God.¹

Theories of this kind rapidly lost ground in the nineteenth century to a new legal positivism. The Austrian jurist, Eugene Ehrlich, writing in that century, spoke of the "living law of the people," based on the actualities of social behaviour rather than on the arbitrary decrees of the state. Ehrlich contended that the rules of everyday life were a nation's effective laws, regardless of whether they were embodied in formal statutes.² Cardozo propounds a similar view when he says:

My analysis of the judicial process comes then to this and little more: logic, and history, and custom, and utility, and the accepted standards of right conduct, are the forces which singly or in combination shape the progress of the law.³

Thus law is no longer seen as fixed, and monomorphic, but as sensitive to the dynamics of social evolution. "The final cause of law is the welfare of society ... the welfare of society fixes the path (of law), its direction and its distance."⁴

This change in the concept of law itself parallels some of the other changes we are discussing, and can plausibly be seen as a reason for the diminishing use of the legal sanction for deterrent and repressive purposes. Moreover, the concept of the 'welfare of society' can hardly be taken to exclude the welfare of the men and women who compose it; and a system of law which is subject to the claims of that welfare must also be solicitous of the interests of the individual citizen. The goals of the pioneer prison reform movements can be seen, therefore, as one particular example

1 Kelsen, Hans, What is Justice? Justice, Law and Politics in the Mirror of Science, Collected essays by Hans Kelsen; University of California Press; Berkeley and Los Angeles; 1957, p. 20.

2 Friedman, W., Law in a Changing Society; Stevens and Son Ltd; London; 1959, p. 165.

3 Cardozo, Benjamin N., The Nature of the Judicial Process, The Storrs Lectures delivered at Yale University; Yale University Press; New Haven; 1921, p112

4 Ibid

of a far broader trend toward greater humanity in dealing with social misfits.¹ To-day also, the demand for changes in the treatment of offenders can only be understood properly if it is viewed as a general and growing concern to make the conditions and means of personal welfare available to all members of the community.

Law; a Function of the Organizational Structure of Society

As we have noted already, we live to-day in a highly complex, heterogeneous society, in which there exists a multiplicity of different values and standards of behaviour. This fact is of immense significance for our system of criminal law. Durkheim maintained that the kind and degree of punishment awarded to lawbreakers and the rationale behind such sanctions have varied according to the organizational structure of a society. In a homogeneous, undifferentiated society, deviant acts of all kinds offend the strongly cohesive conscience of the people. Punishment in such a society has the function of sustaining and reinforcing the collective conscience. It is a mechanical reaction to preserve solidarity, and is in no sense reformatory. One may think of this kind of society as a building in which every brick is a keystone.² In structurally differentiated, urban societies, however, there develops another set of penological principles. The law is not concerned primarily with social solidarity, but with restitution and reinstatement. The law, the court, the judge act as arbiter between the offender and the victim. The very complexity of life demands that the law be designed not primarily to protect society, but to regulate the fluid relations of its members in structurally diverse settings. In such a state, crimes are thought of as acts which offend specific others, rather than as threats to the entire fabric of social life. There is a contraction of the

1 Rose, op cit, p. 16.

2 Lunden, Walter A., "Emile Durkheim," Pioneers in Criminology; Stevens and Sons Ltd.; London; 1960.

normative scope (though not necessarily of the regulatory detail) of the law, and a decreased investment of moral energy in the administration of punishment. Under these conditions, punishment may be applied to the law-breaker in order to reform him. Punishment is modulated in accordance with what is proper for the individual. The rationale for severe punishment is gone, and prisons become hospitals or curative devices to correct aberrations.¹

In complex societies of this type there is no one common standard of behaviour. Law retains the function of preserving peace and protecting the social system, but it does so in deference to a principle of parsimony which seeks no more conformity than is requisite to the maintenance of public order. On the contrary, it explicitly avoids the enforcement of behaviour which is seriously divergent from the beliefs and customs of major subcultures, for this would threaten the very consensuality which supports it. According to Friedman, "It is not possible in a democracy to impose a law on an utterly hostile community."² The aim of law, says Moberly, is to define solutions on grounds that will appeal to the average member of the community.³ Conformity to the law becomes a modal rather than a categorical concept. It becomes possible to consider how the offender may be helped to re-affirm his covenant with his fellow citizens, since he is no longer thought of as having "exiled" himself from the moral community. Criminal law administration assumes the character of accommodation and loses the character of purification. It is in a theoretical perspective like this that we can most clearly see the forms of purpose which constitute the rationale for the representative institution of a forensic clinic.

1 Ibid

2 Friedman, W., op cit, p. 10.

3 Moberly, op cit, p. 30.

The Effect of the Social and Behavioural Sciences

The rapid development of the social and behavioural sciences in recent years has critically influenced our conceptions of the criminal and the way he should be treated. In the face of our heightened awareness of the complex and often obscure causes of human behaviour, it is impossible to view crime simply in terms of sin - expiation, offence - retribution. Furthermore, it is increasingly difficult to impute all blame for criminal behaviour to the offender himself and to disavow our collective participation in his guilt through neglect of the conditions which gave rise to the offence. Although, as Moberly rightly says,¹ the fashionable psychiatric approach to crime has its own extravagant and silly features, it has at least served as a corrective to the bland assumption - traditional in the criminal law - that if a man's actions are not rational they are simply perverse. The social and behavioural sciences have strengthened the disposition to ask why a criminal did what he did, and thus have tempered the disposition to judge him for the fact that he did it.²

A number of novel and serious problems have arisen in connection with what one might call the "encounter" of law and social science. The less than perfectly cordial relations between the different professions involved is probably the smallest of these problems. Even the organizational problem of determining the junctures in the judicial process and the institutional contexts in which social science personnel might be involved - formidable though it is - is a problem of measurable proportions. The real heart of the controversy is to be found in the apparent clash between the scientist's presumption that human behaviour is "determined" (and therefore "irresponsible") and the lawyer's presumption that it is "free" (and there-

1 Ibid, p. 12.

2 Prescor, Michael J.D., M.D., "The Relation of Mental Illness to Delinquency and Crime," Federal Probation, Vol. XVII, Number three, September, 1953.

fore not "caused"); between the medical practitioner's concern with "sickness" and the judge's concern with "guilt." It is quite certain that the future course of criminal justice leads straight into these metaphysical swamplands. But it is equally certain that we cannot remain where we are.¹

The very fact that we no longer feel able to chop off the head of the person who breaks the law forces us into the position of having to find alternative ways of dealing with him. The alternatives eventually adopted will have to be chosen with proper regard for the respective claims and merits of concepts of criminality which at the present time are difficult to reconcile even when they are all in their different ways persuasive.

Rationalizing Behavioural and Judicial Views of Crime

Fortunately, the formulation of the more immediate objectives of penal reform does not have to wait upon the solution of ancient philosophical problems. Nor does the rationale for the establishment of forensic clinics, or (more broadly speaking) the scientific study of crime and the individual criminal, depend on the acceptance of a metaphysic of determinism. The fact is that there are undoubtedly some crimes which are the direct outcome of mental illness even on a conventional view of the matter; and their recognition and treatment require not the overthrow of the criminal law but its liberalization.

The tradition of civilized nations, and the criminal law, has been to take account of the weaknesses of the individual, as a defense against criminal prosecution, or at least a mitigation of punishment.²

Overholser points out that for over six hundred years, lunacy (or

1 For discussion of these issues see Moberly, op cit, and Wootton, Barbara, Contemporary Trends in Crime and its Treatment, Clarke Hall Lectures - 19th Series; Pamphlet published by Clarke Hall Fellowship; London; 1959. Helen Silving, "Mental Incapacity in Criminal Law," Current Law and Social Problems; Volume two; University of Toronto Press; Toronto; 1960.

2 Friedman, op cit, p. 167.

madness) at the time of the criminal act has been available as a legal defence. A "knowledge test" was laid down as early as the thirteenth century. "... a mad man is some one who does not know what he is doing ... a wild beast."¹ Thus the fact that some people under certain circumstances lack the means for the responsible direction of their own behaviour has long been accepted in the law. There are no doubt other cases where people commit crimes and also suffer mental aberrations, though the crimes will not have been the direct outcome of the illness. The existence of these two classes of person among the criminal population does not challenge the basic premise of the law, which is that its provisions ...

... are derived from certain basic assumptions which can be accepted or rejected, but not proved or disproved, so that legal order as a whole is based on the assumption that man is a rational being, and that norms of order in any given society can be based on the hypothesis that the great majority of men and women are capable of controlling their conduct. To deny this assumption means no less than the denial of the possibility of legal order.²

The rehabilitation of the "responsible" offender and the absolution of the "irresponsible" offender both require that we should know far more than we do now about the prevalence, distribution and forms of mental illness in criminal populations, how it may be identified, and how it may be treated. To accomplish this the law needs the assistance of experts in the fields of the behavioural sciences.³ This need is neither novel nor without spokesmen in the legal profession itself. As long ago as 1927, the American Bar Association recommended that every criminal and juvenile court have a psychiatric service to assist the court in its disposition of the offender.⁴

1 Overholser, Winfred, op cit.

2 Friedman, W., op cit., p. 176 - from Mr. Justice Jackson in *Gregg Cartage and Storage Company v. U.S.* 316 U.S. at p. 79.

3 Jayne, Ira W., "Purpose of Sentencing," National Probation and Parole, Volume Two, Number Two, p. 315.

4 Guttmacher, Manfred, M.D., "The Status of Adult Court Psychiatric Clinics," National Probation and Parole, Volume One, Number Two, October 1955, p. 97.

It may also be pointed out that it is manifestly to the public interest - no less than to the interest of the convicted person - that the courts be aware of the social, cultural and psychological factors that have contributed to an offence prior to making final disposition of the case. It is not easy to see how they can otherwise give intelligent service even to the most classically orthodox purposes of criminal law.

... the actual mental status of an offender may be unknown. It is also apparent in some cases there may be favorable factors which, if known to the court, would warrant placing selected offenders on probation while at the same time insuring the protection of society. On the other hand there are cases where if the court was in possession of accurate information with respect to the offender's mental status or unfavorable factors it would be inadvisable to grant probation.¹

There is also an urgent need to adapt judicial rules to the new levels of understanding established by the behavioural sciences. Many reputable authorities have lamented the lack of communication between the law and the newer sciences and the naivety of the law in retaining procedures which rest on obsolete and inadequate theories of behaviour.² Probably the most notorious instance of this is the retention of the M'Naghten Rules, which - for over 120 years - have served as the legal definition of insanity as a defence, despite the fact that they embody a concept of mind which was developed in its essentials in the middle of the seventeenth century. But there are many other examples of a less publicized and less clear-cut kind, such as the simple-minded notions of motivation underlying many sentencing policies.

It is also essential that the causes of crime be not only an object

1 Braithewaite, Lloyd, M.A., and Rouse, Winslow, Ph.D., "The Use of the Reception Centre Diagnostic Services by California Superior Courts Under Section 1203.03 P.C. from 1957 to January 1, 1963." Department of Corrections, California Medical Facility, Vacaville, California, U.S.A., 1963.

2 Silving, Helen, "Mental Illness in Criminal Law," op cit.

of study for social scientists but a discipline for the decision-making of the judiciary. It is knowledge of this kind that will help prevent crime both as an individual "career" and as a species of social disorder. Dr. Leon Radzinowicz, Director of the Institute of Criminology at Cambridge University puts the matter in a perspective which reveals both its possibilities and its limitations in admirably balanced terms.

We should not relax in our efforts to elucidate the causation of crime, the conditions conducive to it and the measures likely to prevent it, without, however, weakening the barriers which the criminal law has erected and without condoning the atrophy of individual responsibility. But the inevitability of crime should be accepted with that sanity which one ought to preserve and foster, as one humbly confesses the mysterious enigma of the human mind and the unpredictable vicissitudes of human society.¹

The warning that Radzinowicz utters here is one that should be kept constantly in mind in projecting new, "scientific" approaches to penology. Mannheim too speaks of the limits to the scope and legitimacy of the psychological treatment of crime. These, he says, are

... partly due to the nature of psychological treatment in general, and partly to the special situation of the offender, partly to the fact that the sentencing court has to consider certain aspects wider than the mere treatment of the individual offender.²

He points out that the inevitable result of the widespread use of devices like treatment tribunals would be an inordinate extension of the applicability of the indeterminate sentence.³ The deprivation of liberty, it must be remembered, is in itself a hardship and an evil. The well intentioned disposition to exonerate those who labour under handicaps may turn out to be a strangely cruel kindness, since the plea of insanity - or even of limited responsibility - means loss of freedom for an indeterminate length of

1 Birkett, Lord (ed), The Newgate Calendar; The Folio Society; London; 1960.

2 Mannheim, Hermann, The Dilemma of Penal Reform; George Allen and Unwin, Ltd.; 40 Museum Street, London; 1939; p. 209.

3 Ibid, p. 208.

time.¹ "It is nonsense to think," said a German prison governor in 1935, "that a short, harsh sentence is more dreaded, than a long one without any severity."² The "individualization" of treatment is by nature a threat to equitability of treatment, and it is imperative that any move to import clinical orientations into the administration of criminal justice be accompanied with appropriate procedural safeguards. Unless the lawbreaker is demonstrably mentally ill, and thus in need of an indeterminate amount of care as any mentally incapable person would be, there are no grounds for abrogating the usual assumptions and procedures of criminal justice: assumptions such as that all men (other things being equal) are presumed to possess the competences necessary for the enjoyment and exercise of civil freedom, that they are responsible for their actions until it be proved otherwise, and that there must be some principle of proportion between crime and punishment. The law would be altogether derelict in its central duties, both to society and to the individual, if it allowed distinctions between the peccadillo and the atrocity, or residual blame and unblushing guilt, to be liquidated in the distinction between health and sickness.³ It is impossible for the law to deal with each individual according to his "unique" needs, for even the attempt to do so would result in intolerable officiousness.⁴ Most convicted criminals would consider it an improvement merely to have the needs that they share with other men recognized by the law.

There is cause for concern, too, at the probable consequences of giving statutory endorsement to the notion that none of us is accountable for what he does.⁵ Criminal law has other purposes besides punishment and

1 Moberly, op cit, p. 20.

2 Mannheim, op cit, p. 71.

3 Weschler, Herbert, "Correctional Practices and the Law," Federal Probation, Volume XVII, Number One, March, 1953.

4 Moberly, op cit, p. 20.

5 Ibid, p. 23.

treatment of the individual offender: it also provides a guide to what we can and cannot do; it is a repository of rules for the rationalization of social life; it crystallizes and dramatizes the abstract principles of political obligation and reciprocity; and its threatened penalties sustain our conduct when temptations are powerful and motivations weak. It is difficult to see what would happen to all this if every act of injury or negligence could be rendered blameless by invocation of a doctrine of universal moral incompetence.

The case for a forensic clinic, then, - as for innovations in correctional practice of a similar kind - is powerful but not absolute. The claim is for citizenship rather than for sovereignty. It provides a means whereby the administration of criminal justice can be made more intelligent and more humane; but it is not intended to be an instrument whereby the traditional principles of criminal justice can be overthrown.

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CHAPTER OUTLINE

The Logical Grounds of the Relevance of Psychiatry to the Study and Treatment of Crime.

The Nebulous Concept of Mental Illness.

Statistical Analysis of Crime and Mental Illness.

The Need for Services in British Columbia.

The Significance of the Clinical Perspective in the Administration of Criminal Justice.

CRIME AND MENTAL ILLNESS

The Logical Grounds of the Relevance of Psychiatry to the Study and Treatment of Crime.

As social attitudes toward the criminal offender change and vindictive punishment is gradually replaced by treatment-centered correction, there is an increasing need for study of the causes of crime. It is generally accepted that knowledge of causation is basic both to the correction of identified offenders and the prevention of criminal activity. Yet there is widespread dissatisfaction with the various etiologies that have been presented so far, reflecting as they do our inability to measure the influence of any one factor as a cause of criminal behaviour. Statistical studies may reveal the prevalence of a certain variable and its connection with a particular type of behaviour, yet this alone will rarely indicate the nature of the presumed causal relationship. Though the influence of a specific factor on the criminal behaviour of one individual might be ascertained with considerable certainty, the uniqueness of the individual and his behaviour make it difficult to systematize the miscellaneous biographical data collected in this fashion in the form of general explanations. This dissatisfaction with the existing theories has led to a veritable quest for some "key" which will unlock the mysteries of the subject, a root principle in criminal behaviour from which all the varied manifestations can be shown to grow. Thus the war of the schools waxes, and wisdom wanes.

For though we may stress a particular cause of crime for a particular purpose, it is evident that there are always many causal factors at work. Since man is a bio-psycho-social animal we cannot say that he is ever

immune to the varying influences of either his biological makeup, his psychic capacities or his social environment, or influenced solely by any one of these. Recent legislation in many jurisdictions reflects the credulous tendency of the courts to accept the sovereign importance of psychiatry in the treatment of crime, and indicates too an unreflecting acceptance of psychic factors as the critical cause of criminal behaviour. This has provoked considerable concern on the part of those who fear that psychiatrists, and correctional workers who subscribe to the same theologies, have concluded that all criminals are mentally ill and should be dealt with accordingly. While some of the more evangelical psychiatrists do believe this, (David Abrahamsen for example), the majority fortunately do not, and clearly recognize the silliness and danger of this glib assumption. Indeed, one of the strongest advocates of the need for care in merging psychiatric knowledge with law is Thomas Szasz, an American psychiatrist, who in reference to this current tendency has said:

...I prefer a broader sociopsychological perspective on crime, which accords psychological factors their proper place, but which holds that criminality, as well as society's methods of combating it, reflect the socio-ethical style of the community....

Crime is a phenomenon that is ethical, legal, and social-psychological, not instinctual-biological and medical. (1)

Thus Szasz and others like him have broken away from the highly individualistic, "clinical" approach traditional with psychiatrists, and have recognized the importance of socio-economical and cultural factors in the development of human attitudes and motivations.

The interaction of psychiatric and sociological variables in the

1. Szasz, Thomas. Law, Liberty and Psychiatry. New York, The Macmillan Company, 1963, pp 110-11.

causation of crime is also stressed by Herbert Bloch (1) who suggests that a given set of socioeconomic and cultural conditions may produce common psychological propensities in those persons affected by them. It is also suggested that the individual will respond selectively to the cultural opportunities and influences which his society provides. Cultural and socioeconomic factors produce different types of tension and maladjustment in different types of social milieux, and psychiatrists should not be allowed to forget this when assessing the forms of psychic life encountered in the socially sealed chamber of the consulting room. It is burdensome, but it is also necessary, to think of human character of behaviour as something obstinately and chasteningly complex, significant at many levels of will, and subject to many kinds of contingency.

Sheldon Glueck (2) suggests that there is a hierarchy of causal influences in crime causation, -- climate and weather, geographic conditions, socioeconomic factors, culture conflict and mental makeup, -- there being no one underlying cause of criminal behaviour. He suggests that we cannot attribute exclusive or even major causal significance to any one of these factors. The preoccupation we may show at any given time with a particular level of causation will be a function and the circumstances and purposes of the very act of investigation rather than a reflection of some fixed order in nature itself. Thus the emphasis on genetic predispositions to delinquency which will be found in the work of the neurologist is not (or ought not to be) a ground for holding that all other "causes" are illusory or epiphenomenal, but the working perspective of the scientist who (for example) is concerned

1. Bloch, Herbert A., "Psychiatry and Sociology," NPPA Journal, Vol. 1, (October 1959), pp. 126-134.

2. Gluck, Sheldon. "Crime Causation", Crime and Correction, Cambridge, Addison-Wesley Press Inc., 1952, pp. 1-23.

with trying to determine what can be learned from electroencephalographic studies. The governing preoccupations of the moment will be (whether we recognize it or not) a product of choice, the result of a decision. The question at issue here, therefore, is a question as to the decision that must be made regarding the etiological biases appropriate to the work of an agency like a forensic clinic.

Giving full recognition to the vital importance of social, cultural, economic and other factors in the causation of all forms of behaviour, including crime, we can nevertheless decide that the analytic perspective best suited to our present purposes is that embodied in a statement by T. C. N. Gibbens - that whatever the predominant influences, (and many are predominantly social), "...they must nevertheless ultimately be expressed through the personality in the criminal act." (1) A forensic psychiatrist should have no doctrinal commitment to the position that minority group status and slum housing play no part in the origins of crime. But at the point at which he begins his professional engagement to its study and treatment, conditions like these have become part of the background of his work: his foreground is composed of those features of the mental life of individual law-breakers which have conspired with constitutional inadequacy, social deprivation and defective laws to generate acts or habits of crime. The eminent position of psychiatry in the field of penology is guaranteed by the special exigencies of decision-making of the law courts; not by its superior scientific competence to sociology, political science, or -- for that matter -- jurisprudence itself.

1. Gibbens, T. C. N. Psychiatric Studies of Borstal Lads. London, Oxford University Press, 1963, p. 6

The Nebulous Concept of Mental Illness.

Many of the problems involved in the extended use of psychiatry in the determination of crime causation and the administration of criminal justice are inherent in psychiatry itself. Psychiatry deals with concepts that are elusive of measurement and therefore looked upon with scientific distrust, and many of its ideas and theories are new and not yet verified by time and use. The nebulous entities with which it deals present special problems in identification and assessment as well as in measurement, and it may be observed that many psychiatrists will disagree over even the most basic postulates about human behaviour.

What is mental illness? It seems there are as many definitions of mental illness as there are theorists, all differing in identifiable characteristics and degree, and frequently even in name. One hears the terms "insanity", "mental illness," "mental disease", "mental abnormality", "mental deficiency", "emotional illness", "emotional disease", "emotional abnormality", "emotional instability" and many others. Some psychiatrists claim these terms are interchangeable while others insist that they signify important diagnostic differences. It is generally agreed that mental illness (this term is used for convenience) can be identified as behaviour which deviates from a norm, but there is considerably less agreement as to what should constitute the "norm", or what degree of deviation constitutes "illness". A leading American psychiatrist, Thomas S. Szasz, even goes so far as to suggest that there is no such thing as "mental illness", and that the term is a metaphor we have come to mistake as a fact. (1) Szasz agrees that the concept of "illness"

1. Szasz, Thomas. Law Liberty and Psychiatry, New York, The Macmillan Company, 1963, p. 14.

implies observable deviation from a clearly defined norm; but he argues that the norm suggested by the term "mental" is almost impossible to define. He points out that should this norm be identifiable at all, it could only be stated as a psycho-social, ethical, and legal principle, and that to attempt to deal with deviations from this within a therapeutic or medical framework is irrational and impertinent.

Even if we put aside objections like these and accept the idea of mental illness, and accept it, moreover, as properly belonging in the sphere of medicine along with physical illness, problems still exist. Henry Weihofen sees "mental disorders" as being failures in the individual's socio-adaptive capacities, which failures are in turn to be regarded as functional responses to external or internal stress. (1) He subscribes to the "holistic" thesis that the "person" is an integrated organism and that the separation of body and mind is not possible. The intellect, the emotions and the will are all interdependent functions of the mind and the basic personality structure is manifested in everything a person does. Disorders therein are judged to be forms of psychiatric disease. Guttmacher and Weihofen state that the functional concept of psychiatric disease is founded on firmly established psychological postulates which admittedly are not susceptible to scientific proof. (2) Mental disorders cannot be lumped together in one chaotic mass, they contend, for psychiatry, as other branches of medicine, has a particular

1. Weihofen, Henry. Mental Disorder as a Criminal Defense. Buffalo, New York, Dennis and Co. Inc., 1954, p. 10.

2. Guttmacher, M. and Weihofen, H. Psychiatry and the Law. New York, W. W. Norton and Company Inc., 1952, p. 14. Though how these postulates can be called "firmly established" when they are not susceptible to proof, the reader may find it as difficult to say as we do ourselves.

nosology and psychiatric clinical entities are as discrete as the cardiac or pulmonary disorders. (1)

There are a great many psychiatrists, however, who do not share this faith of Guttmacher and Weihofen in the diagnostic precision of this branch of the medical sciences; and attention has been drawn to the variety of symptoms psychiatrists identify as being characteristic of particular diagnostic categories, as well as the variety of diagnostic labels given to similar behavioural symptoms. A classic illustration of this confusion is given by August Hollingshead in a discussion of the epidemiology of schizophrenia. (2) Schizophrenia is widely accepted by psychiatrists as a relatively well-defined type of mental illness. Yet since 1900 (Hollingshead points out), there have been six types of theories put forward to account for the etiology of schizophrenia. As a result, there are persistent controversies about the very nature of the illness itself. He refers to a psychiatric congress in 1957, dealing strictly with schizophrenia, in which...

...there was not a single concept or piece of evidence put forward by a participant that was not rejected or challenged by someone else. Even the name "schizophrenia" was disapproved of by several people. Psychiatrists, in brief, disagree about the phenomenology, etiology and therapeutic course of schizophrenia. Moreover, there is controversy over what points they agree or disagree (on). (3)

The way in which a psychiatrist diagnoses a particular (and standard) set of symptoms is often absurdly dependent on the accidents of his theoretical predilections, so that a given number of psychiatrists may diagnose the symptoms of one patient in as many different ways. Hollingshead quotes a study in which six psychiatrists were asked to read field protocols on fifty

1. Ibid, p. 27

2. Hollingshead, August B. "Some Issues in the Epidemiology of Schizophrenia", American Sociological Review, vol. 26, (February 1961), pp. 5-13.

3. Ibid, p. 9.

adult men and rate each man as mentally "well" or mentally "ill". Each psychiatrist diagnosed five men as "well", but the five differed for each of the psychiatrists, one doctor's five "wells" being in another's "sickest" group. (1) The many factors that can affect a diagnosis include not only the psychiatrist's theoretical background, but his idiosyncratic conceptions of particular diseases, as well as the way the patient talks, acts, gestures and thinks differentially between one situation and another, where the notion of "situation" must be taken to include the presence or absence of the psychiatrist himself. (2)

Szasz speaks of the need for an operational approach to the classification of mental illnesses, an approach which takes in the characteristics of the illness, the methods of observation, the social situation in which the observation is made, and its purpose. (3) He claims that the system of classification used in one situation for a particular purpose cannot be equally valid in another situation. For example, the diagnostic vocabulary appropriate to a mental hospital may not be usable in a legal setting, and indeed, very probably will not be.

Psychiatry takes these general difficulties with it wherever it goes (so to speak), but it encounters a whole set of additional problems when applied to the judicial and correctional fields. There is considerable controversy about the proper place of psychiatry in the judicial process. It is no longer restricted to the identification of sanity or insanity and the

1. Ibid, p. 10.
2. Ibid, p. 10.
3. Op cit, p. 27.

ability of the defendant to stand trial but is also used extensively in an advisory capacity for the disposition of offenders. Inconsistencies in the use of psychiatry in relation to criminal behaviour are evident when studies of mental illness in criminality reveal widely divergent results. Winfred Overholser, Walter Bromberg and many others claim that no more than 20 per cent of criminals are mentally ill, while others such as David Abrahamsen and Frederick Thorne claim that all crime is symptomatic of mental disorder of some kind.

Mental illness from the legal standpoint differs in many ways from mental illness from the medical standpoint, and much confusion arises because of a failure to identify the standpoint being used at a given time. The law refers to "mens rea" and insanity - terms essentially foreign to psychiatry. Dr. J. W. Mohr quotes a statement of the American Bar Association to the effect that the term "insanity" should be recognized as a strictly legal concept which has no medical counterpart. (1) Mohr suggests that both the offender and the mentally ill person are defined by reference to certain forms of behaviour which are not tolerated by society, the difference residing in the fact that the notions of guilt, punishment, deterrence and retribution apply only to the offender. In earlier generations, these terms were applied indiscriminately to both classes of deviant behaviour, and this has led to the common and erroneous belief that mental illness and crime are essentially the same, crime being destructive action directed outward and mental illness being destructive reaction absorbed inward.

1. Mohr, J. W. "Prison or Hospital - Some Problems in the Relationship Between Criminal Law and Mental Illness." Unpublished paper presented to the Journal Club of the Toronto Psychiatric Hospital, Sept. 25, 1962. p. 3.

One of the most troublesome diagnostic categories found in the application of psychiatry to law is that of psychopathy. It has in fact been called the "waste basket" of psychiatry into which all chronic forms of delinquency and criminality are indiscriminately tossed. (1) Sutherland and Cressey deplore the vagueness of this concept and quote in this connection a study by Hulsey Cason which revealed the existence of 202 terms used synonymously in the literature for the term "psychopath". (2) Cason also identified 55 characteristics generally held to be present in psychopaths, and 30 different forms of behaviour. On further investigation he found that only two of these characteristics differentiated the most psychopathic from the least psychopathic with any consistency. Lack of agreement as to what constitutes a psychopath is also reflected in the reports of a number of institutions of similar types which confidently list the proportion of psychopaths in their inmate populations at anything between five per cent and 98 per cent!

Even for those (if there be any) who have formed a workable definition and set of diagnostic indicies for this category, psychopathy presents a problem, for the "psychopath" is considered both legally and mentally "sane". and generally, not amenable to treatment. John M. MacDonald (3) defines psychopathy as a neurotic character disorder in which the patient acts out his neurotic conflict in his everyday conduct. This definition immediately calls to mind Abrahamsen's definition of criminality, for it is in fact essentially the same. If we correlate these two definitions, "psychopathy" becomes synonymous with "crime". Still more confusing is the recent tendency

1. Brancale, Ralph. "Problems of Classification", N.P.B.A. Journal Vol. 1, No. 2, October, 1955, p. 120

2. Sutherland, Edwin H., & Cressey, Donald R., Principles of Criminology; Chicago, J. B. Lippincott Company, 1960, p. 126-7.

3. MacDonald, John M., Psychiatry and the Criminal; Springfield, Illinois; Charles C. Thomas, 1958, p. 121.

of many psychiatrists to substitute the term "sociopath" for "psychopath", and then either to use these terms interchangeably or -- if of a different persuasion -- to insist that the issue is not simply a matter of improved nomenclature but of radically different clinical realities.

Nevertheless, "psychopathy" is still a widely used diagnosis, largely because of the lack of more precise and valid diagnoses of the behaviour so described. J. W. Mohr (1) actually uses the ambiguity of the term as a diagnostic criterion, describing the psychopath as one who suffers from personality behaviour disorders which place him in a kind of clinical limbo; perhaps not mentally ill, but a long way from normal. He points out, however, that psychopathic disorder is recognized in more than one piece of legislation, and quotes the British Mental Health Act of 1959 which defines psychopathy as ...

a persistent disorder or disability of mind (whether or not including subnormality of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the patient and requires or is susceptible to medical treatment. (2)

Again, it has for years been taken as almost axiomatic that the psychopath is untreatable. Yet as Max Grunhut (3) points out, the term covers such a range of problematic anti social behaviour that it is possible for a psychopathic patient to encounter some one therapist with whom he can form a satisfying relationship and thus respond to treatment. The psychopath is not committable because he is not insane and because he is mentally "abnormal"

1. Op cit, p. 19

2. British Mental Health Act 1959 - Cited in W. J. Mohr, Op cit, p. 19

3. Grunhut, Max. Probation and Mental Treatment. London Tavistock Publication, 1963, p. 25.

he does not belong in a prison. It is necessary therefore to find an alternative means of dealing with those afflicted in this way. Perhaps by then we may even have some agreement as to just what way it is that they are afflicted!

In studying the available statistics on the incidence of mental illness among criminals we must keep the conceptual confusion and diagnostic imprecision which characterize this subject to the forefront of our minds. The reports of various courts, prisons, court clinics and hospitals often contain widely varying diagnostic categories, and even those using similar diagnostic categories may differ extravagantly in the proportion of prisoners included in a given class or classes. The information so reported, in other words, will seldom be a simple and objective record of the facts, but will almost always in some measure or other be a reflection of the nosological whims of those who collected the information. (1)

1. An excellent discussion of the problems of psychiatry and its application to crime can be found in Thomas Szasz. Law Liberty and Psychiatry.

Statistical Analysis of Crime and Mental Illness.

Despite the difficulties and inconsistencies inherent in psychiatric diagnosis and the problems that occur in adapting psychiatry to a legal and judicial framework, the courts of Canada, Great Britain, and the United States are making ever-increasing use of expert psychiatric opinion in the disposition of criminal offenders. Some legislative provision is made in most courts today for the judge, under certain varying conditions, to request psychiatric assessment of an offender and expert advice as to the most effective rehabilitative disposition. By examining the statistics available from courts using this resource we can get a rough picture of the extent to which various forms of mental illness exist among offenders.

Since forensic psychiatry is a relatively new field, there is as yet a dearth of statistics on this aspect of judicial administration. One can only surmise the reasons for this lack, but it may be assumed that psychiatric services are readily available only to the larger courts so that the smaller courts have no means by which to collect the information in question. It is possible too that there is a lack of really efficient statistical recording even in many of the larger courts. The inconsistencies occurring in diagnosis must also add to this problem. This, however, is not our immediate concern, though it is an important question for further research.

The availability of information about mental illness in criminal populations will naturally depend on the numbers and qualifications of the personnel employed in penal institutions. Many institutions do not have a psychiatrist in their employ at all. A survey by the United Prison Association of Massachusetts (1) in 1954 revealed that in 18 of the 48 states there was no

1. United Prison Association of Massachusetts. As cited in Federal Probation, September 1954, p. 69.

provision for psychiatric services for inmates in any of those states' correctional institutions for adults other than in institutions for the criminally insane. A total of 100 psychiatrists were employed in state adult institutions, less than one third of whom were full time. This brings the ratio of full time psychiatrists to inmates to about 1:5,500, and the ratio of all prison psychiatrists to inmates to approximately 1:1,600.

Charles E. Smith, Medical Director of the Bureau of Prisons reported in 1963 that the most recent count revealed that only 56 psychiatrists were employed full-time in the approximately 230 adult correctional institutions in the United States, 18 of whom were assigned to the Federal prisons. (1) This is only a slight increase over the count of 33 in 1954. Similarly, the ratio of psychological personnel to inmates in adult institutions is 1:1,300, although the recommended ratio is 1:250. (2) Few courts enjoy the full-time services of psychiatrists, and those that have such services at all generally do so by retaining the part-time services of private psychiatrists.

To illustrate the need for more psychiatrists in both the courts and the prison system, Weihofen (3) describes a 1962 study of 100 troublesome inmates out of a total prison population of 1,300 at Clinton Prison, New York, which revealed that 20 were psychotic or had a severe mental illness. Of

1. Smith, Charles E. Psychiatry in Corrections. Unpublished paper, presented in North Carolina, November 1, 1963.

2. Tappan, Paul W. Crime, Justice and Corrections, New York, McGraw-Hill Book Co., Inc., 1960, p. 707

3. Weihofen, H. "Disposition of the Mentally Ill", The Law of Criminal Corrections, Sol Rubin, ed., St. Paul, West Publishing Co., 1963, p. 502.

those 20, 19 had pleaded guilty to the charges laid against them and had been summarily sentenced without any inquiry into their mental condition.

In 1921 the Commonwealth of Massachusetts enacted the so-called Briggs Law which provided that any person indicted by a grand jury for a capital offence, any person known to have been indicted for any other offense more than once, or any person previously convicted of a felony, must be examined by a psychiatrist of the Department of Mental Diseases, "...to determine his mental condition and the existence of any mental disease or defect which would affect his criminal responsibility." (1) The main value of this legislation lies in the fact that all persons in these categories must be mentally examined before trial whether or not they exhibit symptoms of mental abnormality recognizable by the non-expert in mental disease, for example the judge, police officer, or warden. This was an enormous step forward in the use of psychiatric consultation, so much so that it was feared by many that psychiatrists would abuse the law and be inclined to diagnose all offenders examined as mentally ill. However, in 1935 Winfred Overholser (2) conducted a study of 5,172 cases referred for examination under this law from 1921 to 1934 inclusively. The number of cases increased from an average of 73.2 in the first five years to 911 in 1934. Those with abnormalities were classified ✓ as "Insane", "Observation Advised", "Mentally Defective", and "Other Mental Abnormalities". In the first five years an average of 23.4 per cent of those ✓ referred were reported abnormal in some way, but in 1934 only 10.6 per cent of those referred were so judged. Thus, over a period of thirteen years an

1. Massachusetts Act, 1925 ammendment, C169. As cited in "Psychiatric Examination of Persons Accused of Crime", Crime and Corrections, Sheldon Glueck, Cambridge, Addison-Wesley Press Inc., 1952, p. 124.

2. Overholser, W. "The Briggs Law of Massachusetts: A Review and an Appraisal", Journal of Criminal Law, Criminology and Police Science, vol. 25, no. 6, 1935, pp. 859-883.

average of approximately 15.8 per cent of those offenders referred for psychiatric assessment were found abnormal. (Please refer to the following tables, pages II - 19 and II - 20.) It is interesting to note that from 1931 to 1933 only five were diagnosed as "Psychopathic" or Abnormal personality", with none so diagnosed in 1934.

ANALYSIS OF PERSONS REFERRED UNDER THE BRIGGS LAW OF MASSACHUSETTS AND RESULTING DIAGNOSES

From 1921 to 1934

Year ending October 15	Cases reported	Cross examined	% not examined	Insane	Observation advised	Mentally defective	Other mental abnormalities	% reported abnormal
1921-1926 (5 yrs)	367 (av. 73.2 yearly)	295 (av. 59 yearly)	19.6	26	7	25	11	23.4%
1927	138	87	37	5	1	9	1	18.3%
1928	239	179	25.1	6	6	21	13	25.7%
1929	370	283	23.5	3	16	27	11	20.1%
1930	654	521	20.3	4	23	44	10	15.7%
1931	766	703	8.2	8	21	87	10	17.9%
1932	909	817	10.1	6	26	68	19	14.5%
1933	818	725	11.3	3	23	55	15	13.2%
1934	911	782	14.1	5	20	52	6	10.6%
Total	5,172	4,392		66	143	388	96	

Not examined - 780, or 15.1 per cent
of all cases reported.

Total, all classes, 693 or
15.8 per cent of all cases examined. (1)

- (1.) Overholser, W., "The Briggs Law of Massachusetts: A Review and an Appraisal", Journal of Criminal Law, Criminology and Police Science. Vol.25, No.6, 1935, p. 865.

OTHER MENTAL ABNORMALITIES

	<u>1931</u>	<u>1932</u>	<u>1933</u>	<u>1934</u>
Borderline or low intelligence	4	6	10	4
"Psychopathic" or "Abnormal Personality"	2	2	1	0
Epilepsy	2	8	2	0
Drug addiction	0	1	1	1
Organic nervous disease	1	1	0	0
Alcoholism	1	0	0	1
Neurosis	0	1	0	0
"Limited responsibility; not insane"	0	0	1	0
	<hr/>	<hr/>	<hr/>	<hr/>
TOTAL	10	19	15	6

In 1936, Walter Bromberg and Charles B. Thompson (1) reported the results of a study of 10,000 convicted criminal offenders reported to the Psychiatric Clinic from the New York Court of General Sessions between 1932 and 1935 inclusively. They found 2.4 per cent mentally defective; 1.5 per cent insane (ie. psychotic); 6.9 per cent exhibiting Psychopathic Personality ("according to accepted psychiatric criteria"); and 6.9 per cent Psycho-neurotic. Thus of the 10,000 referred, only 18 per cent were found in some way to be mentally abnormal, and on this basis Bromberg and Thompson concluded that Psychosis, Mental Deficiency, and Psychopathic Personality play a relatively minor role in the causation of crime. Nevertheless, 1,800 men showed signs of a need for help in some form, for a psychic condition that may have directly or indirectly resulted in their criminal behaviour.

While these two studies showed 16 per cent and 18 per cent abnormality and 82 per cent to 84 per cent "normalcy" among offenders, in a report on 102 sex offenders at Sing Sing Prison, submitted to Governor Thos. E. Dewey (2) in March 1950, Bernard C. Glueck found that every man showed some type of mental or emotional disorder though not to the extent of being considered legally mentally ill. Of these men; 7 per cent exhibited psycho-neurosis, 22 per cent character disorder; 60 per cent Schizophrenic Reaction, and 2 per cent other psychosis. None of these men, he felt, could be called normal.

Charles E. Smith, Medical Director of the Bureau of Prisons, U. S. Department of Justice, found that under the law T. 18, O.S.C. 4244 et. seq. enacted by Congress in 1949, which calls for psychiatric examination when

1. Bromberg, W. & Thompson, C. B., "The Relation of Psychosis, Mental Defect and Personality Types to Crime", Jr. Crim. Law Crim'y. & P.S., Vol.28 No.1, 1936, p. 70-89.

2. Glueck, B., Jr., "Changing Concepts in Forensic Psychiatry", Jr. Crim. Law, Crim'y & P.S. Vol.45, 1954-55, pp.123-132.

there is any indication that the defendant is mentally incompetent to understand proceedings against him or properly aid in his own defence, one third of the first 200 persons examined were found incompetent and unable to stand trial. In relation to the milder forms of illness and the psychiatric assessment of these as an aid in disposition, Smith found that 15 per cent of 500 consecutive commitments to Federal prisons had "some recognizable mental disorder". (1)

Emmanuel Messinger, M.D. (2) studied psychiatric findings based on the examination over a 25 year period of 57,000 persons who had pleaded guilty to or had been convicted of felonies in the New York Court of General Sessions and had been subsequently referred to the court Psychiatric Clinic. Less than 5 per cent were psychotic (1.5 per cent), neurotic (less than 1 per cent) or intellectually deficient in the ordinary clinical sense (2.5 per cent). The number of offenders evaluated as "psychopathic personalities" rose from 9 per cent in 1931 to between 20 per cent and 30 per cent in 1954 - 57, the average percentage being 24.9 per cent. This change was felt to be due to variations in emphasis on the different criteria used in diagnosis. Various social factors are also believed to have been an influence.

P. DeBaker (3) has analyzed a series of psychiatric reports prepared at Brixton Prison Hospital in England. Under Section 4 of the Criminal Justice Act 1948 offenders whose actions in court lead the magistrate to believe a psychiatric assessment would be valuable, may be remanded for a report on

1. Smith, Charles E., Op cit, p. 5-6

2. Messinger, Emmanuel, "A quarter Century of Court Psychiatry", Crime and Delinquency, Oct. 1961, Vol. 7 No.4 p.p. 343-362.

3. DeBaker, Paul, "State of Mind' Reports", British Journal of Criminology, Vol. 1, July 1960 - April 1961, pp 6-20

their "state of mind". In 1957, Brixton submitted 1,611 reports, or 37 per cent of all such reports requested nationally. In 53 per cent of those cases referred an assessment was made and a diagnostic label attached indicating that some form of treatment was potentially available. The remainder were diagnosed only as "social problem", "immature", or "inadequate personality". For these, no recognized treatment exists, though the reports indicated that some form of social or psychological disorder was present.

The Institute for the Scientific Treatment of Delinquency (1) (known as I.S.T.D.) was founded for the examination and, where possible, the treatment of persons (particularly young people) exhibiting anti-social conduct. While the majority of referrals are from the Courts and probation officers (69.6 per cent in 1941) referrals are also accepted from doctors and clinics, other social agencies, relatives and friends, and from people seeking examination for themselves. Adults as well as youths are treated. In 1941 there were 107 cases of all ages referred to the I.S.T.D. Only two were diagnosed as normal while the largest number, 43, were diagnosed as character cases (psychopathic personalities and sex perverts with no neuroses) and 37 were diagnosed as psycho-neurotic. (Further details of diagnosis are given in the following table, page II - 24). Once again we encounter the problem of establishing what "psychopathic personality" in this instance includes other than faulty emotional development that leads to behaviour legally regarded as delinquent.

The State of California provides a large and growing body of services for those offenders believed to be mentally abnormal. In 1957 the California

1. Glover, Edward; "The Diagnosis and Treatment of Delinquency" in Mental Abnormality and Crime, L. Radzinowicz & J. W. C. Turner (eds) London; MacMillan & Co. Ltd., 1949, pp. 269-299.

Diagnosis of All Cases seen at the Institute for the Scientific
Treatment of Delinquency from 1937 to 1941 inclusive:

	1937	1938	1939	1940	1941
Mentally Defective	4	0	5	6	5
Borderline mentally defective	12	10	22	3	7
Psychotic	7	2	2	1	1
Borderline Psychotic	14	4	9	3	1
Psychoneurotic	48	54	32	34	37
Character cases (including psychopathic personalities and sex perverts apart from neurosis)	58	56	59	42	43
Behaviour Problems	--	--	--	11	0
Cases of organic origin	1	9	7	7	1
Non-delinquent	--	7	11	4	1
Normal	6	0	0	0	2
Alcoholic	2	0	2	1	3
Failed to complete investigation	15	16	10	2	1
	167	158	159	114	102
Add: old cases re-opened but classified in former years	0	8	6	0	5
	167	166	165	114	107

(1)

State Legislative added Section 1203.03 to the Penal Code to provide for the use of the diagnostic and treatment facilities of the Department of Corrections by California superior courts. Any defendant convicted of an offense punishable by imprisonment in the state prison who in the opinion of the court might benefit from such diagnosis and treatment as is available at a facility of the Department of Corrections, may be placed there for a period not to exceed ninety days. At the end of this period the Director of the Department of Corrections must report his diagnosis and recommendations concerning the defendant to the court. Disposition of the case is then undertaken with reference to this recommendation. All male offenders referred for diagnosis under this section are processed at the Northern Reception-Guidance Center at Vacaville (1) From April 1959 to December 1962, 62 men were received and returned to court for disposition. Each man is given a complete psychiatric and neurological examination. The characteristics of the men examined here are felt to be essentially the same as those of the general prison population. A higher percentage (20 per cent) of those with brain damage, was found - probably because of the unusually extensive neurological examination carried out at Vacaville. This has led doctors at Vacaville to believe that there may be a higher incidence of organic brain damage in the general prison population than is commonly supposed. Of the 62 men examined, there were:

Transient Situational Personality Disorders	1	
Personality or Character Disorders	45	
Organic Brain Damage	12	
Psychotic	1	
Mental Retardation or Mental Deficiency	3	
Total	62	(2)

1. Braithwaite, L. & Rouse, W., The Use of Dep. of Corrections --- Unpublished paper.

2. Ibid, p. 3

Not one was diagnosed "normal" as such. However, the low number referred indicates the possibility that referrals are screened by psychiatrists at the individual courts before being sent to Vacaville for observation. The Centre recommended probation in 50 per cent or 31 of the cases. Of these the courts accepted recommendation in 28 cases and denied it in 3 cases. Of the 31 cases in which the Centre recommended against probation, the advice was followed in 23 cases, but probation was granted in the remaining eight. Thus the various courts accepted the recommendations of the Centre in 82 per cent of the cases, suggesting that the diagnostic information was considered useful by the courts. It is not known if further treatment was recommended along with probation.

Winslow Rouse, (1) superintendent of the Reception-Guidance Centre, in a study of mental illness and criminality found that 5 per cent of all committed offenders are mentally ill at the time of admission to prison. Another 10 per cent have histories of mental hospitalization or are borderline psychotics. Previous mental hospitalization, he points out, does not necessarily indicate mental illness since some inmates will have been committed for alcoholism or narcotics use. About 2.5 per cent of the prison population he found to be grossly defective and another 2.5 per cent showed signs of intellectual deterioration. In other words, roughly 20 per cent of the prison population are either psychotic or suffering from an organic defect or intellectual impairment. Dr. Rouse reminds us that these figures apply only to those committed to prison, (who in this case constituted only 29 per cent of all those charged with felonies), and the figures are therefore not an indication of the mental status of all those who commit crimes. The

1. Rouse, Winslow, Ph.D., Letter to the writer January 29th, 1964.

balance of the prison population exhibit personality or character disorders essentially neurotic in origin, though classical symptoms of neurosis are generally absent. Dr. Rouse finds that not more than 5 per cent of a prison population can be classified as sociopathic. While others have attempted to correlate specific types of offences with particular forms of illness, Dr. Rouse believes the offense has little or nothing to do with the nature of the individual's mental or emotional maladjustment, and may not even be characteristic of his ordinary modes of behaviour.

Atascadero State Hospital in California is a 1499 bed security hospital intended primarily for the treatment of the mentally ill offenders. It contains a patient population of 1625, and operates under the Department of Mental Hygiene. Two thirds of the patients are sexual offenders classed as "sexual psychopaths", and the remaining one third is classed as criminally insane. Patients are admitted from courts, hospitals and other institutions under provisions either of the Penal Code or the Welfare and Institutions Code. These include the legal commitments of (1) "not guilty by reason of insanity,", (2) "insanity at the time of judgment" (unable to understand proceedings against him or rationally defend himself), (3) those insane prior to judgment (defined as in No. 2), (4) insane persons under death sentence, (5) persons with a mental disorder who are predisposed to commission of sex offences (returned for treatment only if diagnosed as "sexual psychopath"), (6) mentally abnormal sex offenders (not mentally ill or defective but having committed a number of sex offences) and (7) habitual delinquents (under 21, mentally defective or has a sociopathic personality disorder. (1) Most of

1. Blain, Daniel, M.D., "The Evaluation, Treatment and Disposition of Mentally Abnormal Offenders", unpublished paper presented to Special Commission on Insanity and Crim. Offenders - Santa Monica, Calif., April 14, 1962.

these patients are returned for 90 days observation and diagnosis prior to decisions to treat. In July, 1963 the hospital population was 1616 and these patients were diagnosed in the following manner:

Sexual psychopath, observation (mentally disordered offender)	206
Sexual psychopath, indeterminate (" " ")	653
Mentally abnormal sex offender	42
Mentally Ill	264
Criminally insane	161
Unable to stand trial	264
Psychopathic delinquent	26
	<u>1,616</u> (1)

These patients are released when "improved" in the opinion of the superintendent, and returned to court with recommendations. Many are placed on probation. The sexual psychopath in this case is defined legally by the Welfare and Institutions Code, though it is believed by the hospital officials that "sexual psychopath" is not a sufficiently clear diagnostic entity to justify embodiment in legislation, and they are therefore seeking the repeal of this item in the Code.

In 1963, Max Grunhut published a study of probation and mental treatment in England (2). Statutory provisions for the mental treatment of probationers for a 12 month period is laid down in Section 4 of the Criminal Justice Act of 1948. Mental treatment under this section applies to offenders who are in need of and susceptible to medical treatment, and yet have committed a criminal act with a guilty mind. Candidates for probation under these conditions are first selected by the bench but subsequent assessment by a medical

1. Unpublished information. Atascadero fact sheet.
2. Grunhut, Max. "Probation on Mental Treatment", London; Tavistock Publications, 1963.

witness or psychiatrist is mandatory. The bench decides on a basis of the behaviour of the defendant in court, the nature, frequency and circumstances of the offence, the health of the defendant, his family conditions and other criteria. The medical opinion must take into account the defendant's personality, past experiences and present mental condition and whether he is in need of and susceptible to treatment. In practice it seems that medical opinion is sought only in a fraction of the cases exhibiting these symptoms. Treatment can be designated as residential or non-residential, slightly more than half receiving non-residential treatment. The study shows that in 1958 only 2.3 per cent of those placed on probation had a treatment requirement. (The table entitled "The Incidence of Section 4 Requirements Among Probation Orders in 1958", page II - 30, gives an idea of the statistics regarding this requirement by age.) The 414 probationers placed in treatment were classified as follows:

Psychopathic personality (constitutional)	154
Psychopathic personality (environmental)	41
Low intelligence	28
Schizophrenia	58
Illness with a physical basis	36
Anxiety state	15
Adolescent neurotic tendencies	2
Ill defined neurotic illness	23
Depression	52
No ascertainable abnormality	5
	<hr/> 414 (1)

Grunhut calls attention to the odd and self-contradictory feature of the large number of psychopaths in the group, when almost by definition these persons are generally considered untreatable. (The relationship between mental condition and type of offence can be seen in the table entitled "Breakdown of Type of Offence in Relation to Psychiatric Diagnosis", page II - 31. Grunhut, unlike Rouse, believes this to be a relationship of some significance).

THE INCIDENCE OF SECTION 4 REQUIREMENTS AMONG PROBATION ORDERS IN 1958 (1)

	Under 17		17 and under 21		21 and under 30		30 and over		Total
	M	F	M	F	M	F	M	F	
Total of probation orders made during the year	19,101	1,954	6,567	1,383	4,261	1,160	3,674	1,589	39,589
Probation orders with a section 4 requirement	124	3	89	14	199	26	367	87	909
Percentage	-	-	-	-	4.6	2.2	9.9	5.4	

II - 30

1. Grunhut, Max, Probation and Mental Treatment, London; Tavistock Publications, 1963, p. 9.

BREAKDOWN OF TYPE OF OFFENCE IN RELATION TO PSYCHIATRIC DIAGNOSIS (1)

Diagnosis	Type of offence												Total
	23	24	25	26	27	28	29	30	31	32	33	34	
Psychopathic personality	59	7	3	6	13	3	13	10	33	16	6	26	195
Low intelligence	7	3	-	3	6	-	1	2	2	-	-	4	28
Schizophrenia	13	1	1	2	2	-	4	2	2	5	8	18	58
Illness with physical basis	9	-	4	-	1	-	2	2	6	4	2	6	36
Anxiety states	6	1	-	1	2	-	1	1	1	-	1	1	15
Adolescent immaturity	-	-	-	-	-	-	1	-	1	-	-	-	2
Ill-defined neurotic illness	5	2	-	1	2	-	1	2	4	1	3	2	23
No abnormality	-	-	-	-	1	-	-	-	3	-	-	1	5
Depression	9	1	1	-	-	-	1	1	3	25	6	5	52
	108	15	9	13	27	3	24	20	55	51	26	63	414

Key to offences: 23, larceny; 24, breaking and entering; 25, shoplifting; 26, other possibly pathological stealing; 27, heterosexual offence (child victim); 28, heterosexual offence (adult victim); 29, homosexual offence (child victim); 30, homosexual offence (adult victim); 31, indecent exposure; 32, attempted suicide; 33, violence against the person; 34, other offences.

1. Grunhut, Max, Probation and Mental Treatment, London; Tavistock Publications, 1963.

In 22 cases, no treatment was considered possible. The main form of treatment for those who did receive it was psychotherapy.

It is interesting in examining a study in which the connection between mental illness and crime is quite explicit, to note the results of treatment. The medical evaluation given at the conclusion of the period of mental treatment, for 369 persons was as follows:

Condition improved	141)	70 per cent
Some benefit	114		
Condition not improved	77		
Treatment continuing	22		
Certified	9		
No information	6		
	<u>369</u>	(1)	

Grunhut emphasizes that the results of treatment do not depend only on the mental and physical condition of the offender, but also on social background that can be mobilized in his support, such as favourable family relationships and the assets of a good work record and no previous convictions. Two thirds of the probationers who received treatment terminated probation satisfactorily, probation having continued on after treatment ceased. Almost half (42 out of 98) with unfavourable prognoses terminated satisfactorily. One year after termination of probation 32 per cent of the men had been reconvicted. However only one out of every five of those with favorable prognoses was among these. Many of those with unfavorable prognoses (54 out of 128) did not repeat. Greater success in the outcome was achieved when the same doctor who diagnosed also treated the patient. It was felt that the present 12 month time limit on treatment is in many cases insufficient, though it is recognized that this limit is set to protect the personal rights and liberty of the

probationers. Section 60 of the Mental Health Act of 1959 makes it possible in some cases to make guardianship orders and hospital orders to obtain further treatment without probation. In England, Section 4 of the Criminal Justice Act 1948 is applied widely to criminal offences of every type and degree. In relation to the total numbers of comparable offences committed, however, the number of cases for which this disposition is used is still small.

The Annual Reports of the Commissioners of Prisons in Great Britain for 1961 and 1962 indicate a rise in the number of prisoners found to be mentally defective in some way. In 1961 (1) of the total prison population, 6,366 prisoners were remanded in custody for investigation of their mental condition. Of these 518 were found "mentally ill", 41 were "severely sub normal", 242 "subnormal" and 37 were found to have a "psychopathic disorder". Those found "insane on arraignment" numbered 39 and those found "guilty but insane" numbered 10. In addition 293 inmates were diagnosed as suffering from epilepsy. One hundred and eighty prisoners were removed to hospitals for treatment under provisions of the Mental Health Act.

In 1962 (2) of the total prison population, 7,015 were remanded in custody for psychiatric investigation. From this number, 918 orders were made under the Mental Health Act; and of these, 570 were "mentally ill", 48 were "severely subnormal", 258 were "sub normal" and 42 were diagnosed as having a "psychopathic disorder".

The same Report announces the long-awaited opening of H. M. Prison, Grendon, under Dr. W. J. Gray, Medical Supervisor and Governor. This is a

1. Report of the Commissioners of Prisons For the Year 1961; Command Number 1798, London; Her Majesty's Stationery Office. 1962.
2. Report of the Commissioners of Prisons For the Year 1962, Command Number 2030, London; Her Majesty's Stationery Office 1963.

prison hospital for the treatment and management of the sentenced mentally abnormal offender. The three primary tasks of this prison hospital are: (1) the investigation and treatment of disorders generally recognized as responsive to treatment in suitable cases; (2) the investigation of offenders whose offences in themselves suggest mental morbidity; and (3) an exploration of the problems of dealing with the psychopath. In the first year of operation Grendon had 98 prisoners, 61 of whom were a working party only, receiving no treatment. The 37 prisoners under treatment were categorized in the following fashion:

Anxiety or other neurosis	6	
Unstable or inadequate personality	4	
Drug addiction	1	
Homo sexuality	9	
Paederasty (all homosexual but 1)	5	
Rape	1	
Psychopathy	3	
Epilepsy for investigation	3	
Psychosis for investigation	1	(1)

While the number classed as psychopathic is small, many of the others have psychopathic personalities. It is not explained why some of these categories should be clinical and others judicial.

The Toronto Forensic Clinic of the Toronto Psychiatric Hospital, (described in greater detail in Chapter III), offers diagnostic and treatment services to persons referred from many sources, but primarily from courts and probation officers (2). Of a total of 326 new patients in 1962, 214 were referred from these two sources, 77 being from the courts and 134 from probation officers. Court referrals are made under the Ontario Mental Hospitals Act and the majority of these are pre-sentence cases. Those cases ordered

1. Ibid, p. 60

2. Fifth Annual Report, 1962, Forensic Clinic, Toronto; Toronto Psychiatric Hospital.

by the judiciary and magistrary to attend the clinic for treatment as a condition of probation are included in the number referred by probation officers. If treatment is not possible this part of the probation order can be amended or waived. Of the total 326 new patients accepted at the clinic in 1962, 160 were sexual deviates. These were included in the 212 patients diagnosed as Disorders of Character, Behaviour and Intelligence. The next largest diagnostic group was the Personality Trait Disorders which accounted for 52 out of the total.

Dr. R. E. Turner has presented an analysis of statutory referrals to the Clinic between May 1956 and December 1960 (1). These referrals he found to account for an average of 16.7 per cent of all new cases received by the Clinic. The major psychiatric diagnostic categories were: Sexual Deviation 37.2 per cent, Immature Personality 12.1 per cent, Psychoneurosis 11.5 per cent, Pathological Personality 10.9 per cent, Psychosis 8.5 per cent and others 19.5 per cent. (Further breakdown of these shown in the table entitled "Psychiatric Diagnoses", page II - 36). The legal classification of offences was: Crimes against the Person 9.1 per cent, Crimes against Property 28.2 per cent, Crimes against Public Morals & Decency 48.04 per cent, Crime against Public Order & Peace 10.2 per cent, and others 3.7 per cent. After diagnosis, recommendations made to the courts consisted of: treatment at Forensic Clinic 56.7 per cent (72.0 per cent of these were accepted), other treatment 17.1 per cent, and no treatment recommended 26.2 per cent. (An interesting breakdown of non-sexual offences and the psychiatric diagnoses involved is reproduced in the table entitled to this effect, page II - 37. This table was compiled from the clinic statistics from May 1956 to September 1959).

1. Turner, R. E. & Jerry M. Statutory Referrals to the Forensic Clinic, Toronto. Unpublished paper presented to the Third Research Conference on Criminology and Delinquency in Montreal, Nov. 20-24, 1962.

PSYCHIATRIC DIAGNOSES (1)

	N.	%	Total	
			N.	%
<u>SEXUAL DEVIATION:</u>			61	37.2
Pedophilia	26	15.9		
Exhibitionism	18	11.0		
Homosexuality	11	6.7		
Latent Homosexuality	2	1.2		
Fetishism	1	0.6		
Bestiality	1	0.6		
Incest	1	0.6		
Transvestism	1	0.6		
<u>IMMATURE PERSONALITY:</u>			20	12.1
Other and Unspecified	14	8.5		
Passive Dependency	3	1.8		
Emotional Instability	2	1.2		
Aggressive	1	0.6		
<u>PSYCHONEUROSIS:</u>			19	11.5
Neurotic Depression	7	4.3		
Obsessive Compulsive	5	3.0		
Other and unspecified	3	1.8		
Hysteria	2	1.2		
Mixed	2	1.2		
<u>PATHOLOGICAL PERSONALITY:</u>			18	10.9
(Other than Sexual Deviation)				
Anti-social - psychopathic	8	4.9		
Other and unspecified	5	3.0		
Asocial	2	1.2		
Inadequate	1	0.6		
Schizoid	1	0.6		
Paranoid	1	0.6		
<u>PSYCHOSES:</u>			14	8.5
Schizophrenic	12	7.3		
Manic Depressive	1	0.6		
Paranoid State	1	0.6		
<u>PRIMARY CHILDHOOD BEHAVIOUR DISORDER:</u>			11	6.7
<u>ALCOHOLISM:</u>			6	3.7
<u>MENTAL DEFICIENCY (Imbecility):</u>			3	1.8
<u>SIMPLE ADULT MALADJUSTMENT:</u>			1	0.6
<u>EPILEPSY:</u>			1	0.6
<u>NO PSYCHIATRIC DISORDER FOUND:</u>			10	6.1
Undiagnosed. Also not seen by doctor				
			164	99.7

1. Turner, R.E. An Analysis of Statutory Referrals to the Forensic Clinic, Toronto. May 1956 - December 1960, Table 7.

Toronto Forensic Clinic: Cases Not Involving Sexual Offences or Problems.
May, 1956 - September 1959 (1)

Offences Against Property
(Theft, Breaking and Entering, False Pretences, etc.)

<u>Male</u>	<u>Female</u>	<u>Diagnosis</u>	<u>Number</u>
119	17	Neurosis	14
		Psychosis	8
		Character Disorder	78
		Adolescent Reaction	29
		Undiagnosed	7
			<u>136</u>

Offences Against Person
(Assault, Wounding, Contributing to Juvenile Delinquency, Etc.)

<u>Male</u>	<u>Female</u>	<u>Diagnosis</u>	<u>Number</u>
26	2	Neurosis	9
		Psychosis	2
		Character Disorder	16
		Adolescent Reaction	1
			<u>28</u>

Other Offences
(L.C.B.O. Violation, Breach of Probation.
Highway Traffic Act, and Others)

<u>Male</u>	<u>Female</u>	<u>Diagnosis</u>	<u>Number</u>
22	6	Neurosis	4
		Psychosis	4
		Character Disorder	11
		Adolescent Reaction	6
		Undiagnosed	3
			<u>28</u>

Statistics regarding the occurrence of mental illness among offenders in British Columbia are particularly scarce. This, it is assumed, is mainly due to the dearth of psychiatric services available to our courts and institutions.

Oakalla Prison Farm is a provincial jail with an average daily population of 1,100. The inmates, aged from sixteen years upwards, are serving terms up to two years less one day. Sentences two years and over are served at the B. C. Penitentiary, which is the federal prison. There is no psychiatrist employed at Oakalla at all, although the medical director, Dr. R. G. E. Richmond, has had extensive psychiatric experience. A psychiatrist from the Provincial Mental Hospital at Essondale, Dr. MacGregor, visits Oakalla for a few hours each week but sees only those prisoners Dr. Richmond feels should be sent to Essondale. Dr. Marcus, psychiatrist at the observation unit of Vancouver General Hospital, sees a few offenders from Oakalla on an out-patient basis. One part time psychiatrist is assigned strictly to those prisoners who are drug addicts.

From April 1st, 1963 to March 31st, 1964, 301 prisoners were seen by Dr. Richmond at the hospital in Oakalla. These persons were diagnosed as follows:

Alcoholics	109
Drug addicts	27
Personality Behaviour Disorders (Sociopaths)	89
Schizoid Personality Types	42
Brain Syndrome	3
Drug Overdose	2
Glue Sniffing	4
Sexual Deviates	2
Anti-social	4
Other	19 (1)

In this year a total of 100 prisoners were committed to Essondale from Oakalla. Many of these were examined by the court psychiatrist, Dr. Thomas, on a pre-conviction basis and not seen by Dr. Richmond in the prison hospital.

1. Interview with Dr. R. G. E. Richmond of Oakalla.

They are, however, considered to be part of the prison population since they are remanded to Oakalla from the courts to await examination. Of this 100 there were:

Personality Behaviour Disorders	31	
(Sociopaths)		
Schizophrenics	63	
Brain Damage	2	
Anti-social	4	(1)

Dr. McGregor, consulting from Essondale, interviewed and prescribed treatment for 90 of the 301 examined. Dr. Marcus at the Vancouver General Hospital saw 64 prisoners in the year over and above the 301 mentioned above, and prescribed treatment and medication and in some cases administered electro-convulsive therapy. (A diagnostic breakdown of this 64 was not available). We can see from these statistics that the psychiatric services available to the prison are hardly adequate to serve the prisoners in need of psychiatric attention.

The British Columbia Penitentiary is the Federal Prison housing those prisoners serving sentences of two years and over. Since most prisoners first go to Oakalla, those needing psychiatric help are frequently weeded out there.

In the year April 1st, 1963 to March 31st, 1964, (with an average daily prison population of about 730), eight prisoners were sent to Essondale Mental Hospital for treatment. These were classified as:

Paranoid Schizophrenics	2	
Reactive Depression	1	
Confusion	1	
Hyperthyroid Confusion	1	
Others	3	(2)

All of these are considered in some way "sociopathic" or "psychopathic anti-

1. Ibid.
2. Interview with Dr. MacDonald.

social".

Dr. D. C. MacDonald is the only psychiatrist available to the prisoners at the Penitentiary and he is there only on a part-time basis. Dr. MacDonald sees at least five prisoners every morning, plus a group of six to eight prisoners once a week. He has stated that three full-time psychiatrists are needed to provide adequate services. Many of the prison population are mentally defective in some way, he claims, but no statistical break down on this is available.

It can be seen from this sampling of statistics that on the average, approximately 20 per cent of all known offenders are believed to be suffering from some form of mental illness. In some areas this percentage is higher and in a few it is lower. Since differing diagnostic categories are used by the various institutions it is difficult to estimate the total percentage of prisoners suffering from any one type of illness. The percentage of psychopaths, in particular, would be beyond conjecture, since even those studies including psychopathy among their diagnostic categories which bother to define it use widely varying criteria of identification. Nevertheless, if through psychotherapy or any other form of psychiatric treatment we can correct or improve the anti-social behaviour of even 20 per cent of our offenders, the introduction of the means of providing such services would be well justified, and both the well being of the individual criminal and the protection of society would be far better served than they now are.

It must be remembered that the data contained in these various reports are skewed by many factors: the legislative provisions under which the psychiatric examinations were carried out; the conditions under which the judge or warden made his decision to refer the offender for assessment; the type of institution reporting and the adequacy of services available to it; the theoretical orientations of the examining psychiatrists, their idiosyn-

cratic conceptions of the different diagnostic categories and the behavioural indices by which they apply them; these are only a few of the factors influencing the results of such studies, and we must make allowances for them in interpreting the data reported. A fully adequate assessment of the statistics given above would include a complete account of all these sources of bias; but that in its turn is impossible since we have no means even of standardizing the data by reference to known limits of error.

The need for Services in British Columbia

Admittedly, the statistical picture of the incidents of mental illness among criminals in British Columbia is not clear. With the meagre services available to our institutions and the limited use of remand for psychiatric assessment by our courts, we have no way of knowing the precise extent of mental abnormality among our offenders, nor will we have until sufficient psychiatric services are available to assess the problem and determine what our correctional system actually needs in the way of diagnostic and treatment facilities. The fact remains, however, that the crimes committed by these offenders are of rising and major concern to the general public. This concern has been brought to an unusual pitch in recent years by the erroneous and even sensational coverage given by the local press to a number of particularly shocking crimes of violence. The following are a few of the more dramatic cases of this kind that have occurred in the past five years.

Douglas Brown, a popular football player who had been committed to Alberta's Ponoka Mental Hospital in the fall of 1961 and released in the spring of 1962, shot and killed a priest on April 16, 1963 in Vancouver. (1) He was determined mentally ill and is now being treated in the Provincial Mental Hospital at Essondale. There is no evidence that he was receiving any psychiatric after-care following his release from hospital in Alberta. In June, 1962, George Booth, a 32 year old parolee from Essondale, killed three Royal Canadian Mounted Police officers and was subsequently hunted down and shot to death by an R.C.M.P. posse. (2) In 1961 Gilbert Elsie, a 32 year old offender with a long record of theft and imprisonment was found fit to

1. The Vancouver Sun, January 28, 1964.
2. The Vancouver Sun, August 12, 1963.

stand trial after making a suicide attempt on Lion's Gate Bridge in Vancouver. The following year he was sentenced to six months in jail for contempt of court when he threw books at the magistrate. In 1963, following another theft conviction, he was sentenced to the British Columbia Penitentiary (apparently in all seriousness) "...for psychiatric care". (1) We have already examined the psychiatric care available at that institution.

Three other cases have also, in recent years, received a great deal of public attention, -- though "public attention" is a euphemism for some of the shriller popular reactions. In July of 1963, two brothers, Kenneth Lloyd Meeker, 30, and James Leonard Meeker, 35, were arrested for the sex slaying of a twelve year old girl. (2) Neither of the brothers sought counsel and a lawyer had to be appointed. In November 1963, Kenneth made a confession to the police. After a trial during which his lawyer, without taking any psychiatric advice, declared Kenneth "not legally insane", Kenneth was sentenced to death by hanging after a forty minute jury deliberation. The sentence was appealed on the grounds of intoxication in March 1964, and once more guilt was declared and the death sentence imposed. In late March, an appeal was made to the Supreme Court of Canada, and once more the hanging was postponed. During this time, Kenneth's wife abandoned their five children, leaving them homeless. In the meantime, James Meeker was sentenced to ten years in the Penitentiary for having had unlawful intercourse with a juvenile, the judge opining that, since James had not learned better from previous sentences, his chances of rehabilitation were remote. The public clamoured for a heavier sentence, and though the Attorney General made it clear that the Crown had no means of imposing one, he did instruct the police to lay a charge of rape of an older woman in an earlier incident. According to news-

1. The Vancouver Sun, August 12, 1963.
2. The Vancouver Sun, July 3, 1963.

paper reports, there has been no mention of psychiatric investigation of either of these men. Should James Meeker be released after his present ten year sentence, there is no assurance that he will have received psychiatric assessment, or that treatment would be available even if an assessment were made.

Charles Murrall Heathman was arrested in September 1960 for the sex slaying of a ten year old boy and subsequently sentenced to be hanged. His case was appealed in Assize Court in May 1961 and another jury took fifty-two minutes to declare him guilty. A second appeal in October resulted in his acquittal. In April of 1962 Heathman sold a "confession" to The Vancouver Sun for \$500.00 and a guaranteed margin of twelve hours to escape. In this confession he claimed to be a "psychopathic Killer". A warrant was issued for his arrest and he was apprehended in the United States and returned to Canada to face charges under the Canadian Mental Health Act. He was remanded for psychiatric examination, and though he had by now retracted his confession, two psychiatrists declared him mentally ill, "...dangerous, callous and anti-social". In May 1962 he was committed to Essondale. In January 1964 Heathman's pending release was announced by the hospital and a public reaction of something akin to panic ensued. An appeal was sent to the Attorney General that he prohibit Heathman's release, but there were no statutory grounds on which he could do so. On February 12, 1964 Heathman was released, on the approval of two physicians, into the custody of an unknown sponsor in an unrevealed community, on a probation requiring regular psychiatric examination. He disappeared from his sponsor's home on February 19, 1964 and in March was found to be living in Winnipeg, where he tried to sell his story to the press once again. Later the same month he was arrested on a charge of possession of narcotics, and subsequently found guilty and sen-

tenced to imprisonment.

Events like these have naturally precipitated an animated public discussion of the possibility of averting similar occurrences in the future, and much has been said in particular about the problem of the so-called "Psychopath." Mr. John V. Fornataro, Assistant Professor of the University of British Columbia, School of Social Work, took the occasion to deplore the irrational and vengeful temper of mind excited by these events in some quarters, and at the same time, challenged the traditional view (revived for the occasion) that psychopaths are generally "born bad". (1) He quoted the United Kingdom Commission on the Law Relating to Mental Illness and Mental Deficiency of 1957, pointing out that psychopathy often seems to have its origins in the individual's social environment. He drew attention also to the discrepancy between the intensity of expressed concern with the problem -- both popular and official -- and the almost complete absence of facilities in the province for the detection and treatment of psychiatrically disturbed and potentially violent law-breakers. His remarks on that occasion are germane to our present concerns.

British Columbia has more than a fair share of Canada's social and emotional problems. But it has no forensic clinics - even for juveniles - it cannot boast of therapy in its penal institutions, nor of research on which to establish something better... (2)

The B. C. Parent-Teacher Federation also presented proposals for a clinic "...to provide treatment for sexual offenders and emotionally disturbed children and adults". (3) Dr. Patrick McGeer proposed in the Provincial Legislature that the Provincial government should finance and establish a

1. Fornataro, John V. Letter to the Editor, Vancouver Sun, Jan. 6, 1964.
2. Ibid.
3. The Vancouver Sun, March 5, 1964.

forensic clinic for the study of sexual psychopaths and other criminal offenders. (1)

These are the more sensational cases, but many more offenders in British Columbia appear in the courts with long records of less spectacular offences. In January 1964 an almost forgotten section of the Criminal Code regarding habitual offenders was reactivated, and since then a number of persons have been threatened with this charge. The Habitual Offenders Act provides that persons with three previous convictions for serious offences may be prosecuted as a habitual criminal and sentenced to indefinite confinement, with a yearly review of eligibility for parole. (2) Press reports indicate that proceedings have been launched against at least six persons under this act in the past three months.

In the first three months of 1964, Vancouver courts have reported a number of cases to the press wherein persons were facing new charges after a long history of previous offences and sentences. In January, one man was found to have been convicted of 37 offences of theft, breaking and entering and possession of narcotics, and had served a total of eight years in prison. (3) In February, two other men faced habitual criminal charges. A third man now serving a six month jail term for shoplifting has had 28 convictions since 1936 for such offences as armed robbery, breaking and entering, theft, false pretences and vagrancy. A nineteen year old was also warned of a pending "Habitual" charge. Still another man now serving a five year term for a 35 cent burglary faces "Habitual" charge in view of 25 convictions since 1950. Sentences (including "concurrent" terms) for his con-

1. The Vancouver Sun, February 19, 1964.
2. The Vancouver Sun, January 27, 1964.
3. The Vancouver Sun, January 21, 1964.

victions total over 42 years.. This is but a sample of the large number of people with similar records of anti-social behaviour appearing before our courts. The most obvious inference to be drawn from their careers of crime is that our customary methods of dealing with them have been strikingly ineffective. The clear implication of this in turn is that we need to know a great deal more about such people than we presently do if our penal system is to achieve systematically better results. And that is surely one of the hinges of the case for a forensic clinic.

The Significance of the Clinical Perspective in the Administration of Criminal Justice.

With the apparent increase in the frequency with which psychiatric opinion is sought by the courts to aid in the disposition of offenders, the lack of facilities for carrying out psychiatric recommendations has become brutally obvious. It has been pointed out by numbers of penologists that psychiatric opinion is useless to the courts unless facilities exist in the community to offer the services presumed in the very formulation of those opinions. Since diagnostic studies are required on individuals referred to the psychiatrist before recommendations can be made to the court, it is necessary to have the facilities in which this can be done with despatch and efficiency. Similarly, if the psychiatrist recommends a particular kind of treatment, there must be some means of making this treatment available to the offender. Mental hospitals are already over-crowded and understaffed, and few of those appearing before the courts could afford private psychiatric treatment. With the psychiatric services available in the penal institutions of British Columbia being almost non-existent, treatment in prison is presently a dream. A forensic clinic would have the task of recommending "treatment", providing treatment, and improving treatment. But if our correctional services remain fixed in their present state, the effect will be something like that of shouting into the wind.

The functions of a forensic clinic are discussed in detail in Chapter IV, and it is not our purpose here to anticipate what is said there from a somewhat different though complementary point of view. But the evidence concerning the extent of psychopathology in criminal populations which has been reviewed in the present chapter both prompts and supports an observation which is no less germane at this juncture for being at issue also at other

points in the study. That observation has to do with the essential independence of the case for a forensic clinic of the belief that all criminals are mentally ill and that all sentencing is a species of medical planning. To make the establishment of such a facility hang upon the acceptance or rejection of this claim would be to do a vast disservice to the whole project. It would alienate those who would be prepared to endorse a more modestly conceived undertaking; it would suppress all questions of priorities by putting criminals of every type into the same category of need; and it would commit the clinic from the outset to a confiningly "psychiatric" mode of operation.

We can see from the statistics given above that mental illness is evident in approximately twenty per cent of offenders appearing before the courts, and we must therefore have facilities available to treat these illnesses. But what of those who are not "mentally ill" and who are subject to social or economic pressures with which they are unable to deal in a socially acceptable manner? Surely the courts have a reasonable concern with these non-medical varieties of handicap as well.

A problem accordingly arises as to how those persons suffering from socio-economic stress as well as suspected mental illness should be referred to the clinic by the courts. One rule-of-thumb but apparently effective approach to the problem is described by the eminent forensic psychiatrist, the late Sir Norwood East.

In selecting the cases which appear to require a medical examination I find much help from the reports of probation officers, the police, welfare workers, parents and others. The manner, facial expression and general appearance of the offender in court may be significant. Repeated offences, particularly of the same kind recurring sexual offences, and conduct which appears to lack common sense and is out of proportion to the circumstances, together with a lack of foresight out of keeping

with the age and experience of the defendant may indicate the importance of a physical or mental report. (1)

Decisions to refer on the basis of conduct in court or in custody alone may, of course, be very unreliable since it is possible that severely disturbed persons could (and often do) conduct themselves in an extremely cooperative, pleasant and conforming manner under these circumstances. For this reason it is important that reports of probation officers and information supplied by relatives, welfare workers and other collateral persons be examined carefully, and that the offender's conduct be examined in the light of his customary way of behaving. With a variety of sources to consult, the magistrate or judge is likely to detect suspected problems of mental illness with greater accuracy, and fewer disturbed offenders will go unnoticed. With the same material, providing the probation officer's report is complete, it would be possible to detect these offenders who are suffering undue social and economic stress, or who are living under adverse social conditions which have led them into conflict with the law. These persons could then be referred to the clinic for assessment of the affect of these conditions on their behaviour. Should the diagnosis reveal that there indeed is such a "causal" relationship, the offender might then be referred back to the clinic from the court for work, (possibly with a social worker), in an attempt to bring about some change in his social conditions; or if this should not be possible, to help him adapt to the situation in as satisfactory a manner as the circumstances will allow.

In other words, to enable the courts to make dispositions that will most effectively correct the behaviour of the offender and prevent further occurrences of the objectionable behaviour, the clinic must offer as complete

an assessment of the spectrum of relevant circumstances as possible. It is hard to see why the benefits of penological enlightenment should be restricted to those criminals whose problems are all in their heads! (1)

In the last analysis, the rationale for agencies like forensic clinics lies not in the novelty of the discovery that a sizeable group of criminals give signs of being mentally ill, but in the moral significance we attach to the work of the courts of law -- and the other institutions of social control -- in general. After all, it is not so long since it was perilous enough merely to be mentally ill; and sickness will provide no claims upon the solicitude of the healthy unless they acknowledge it as a ground for the performance of a duty of care. It is re-assuring to learn that the lessons of practical experience are of a piece with the teachings of moral principle; and they are so combined in the following excerpt from a letter received from Mr. C. Arthur Choate of the Atascadero State Hospital of California.

"The need for and potential use of forensic clinics is going to be determined largely by the culture and sub-culture in which they exist. If the public is primarily concerned with protection and retribution because criminals are "bad", these needs can best be served by large institutions that segregate their population from the community and where life is less tolerable than in the general community. If criminals are seen as individuals who are by-products of your particular cultural, social, economic and family patterns, who would be different if they had the opportunity, then forensic clinics are of value. It must be remembered that a community does not enter into an out patient treatment program without a risk. The question is, are the gains to the individual, to the family, and to the community, worth the risk to which the community is subjected. This is primarily a matter of values rather than one of statistics.

"...It is extremely important not to oversell to the public or the members of other social institutions what can be expected from clinical settings. If you can establish clinics on the basis of respect for the integrity and value of the individual in the primary family group and the fact that all larger groups are dependent on the functioning of these units, you are on safe ground. If you establish them on the basis that they will

1. Braithwaite, L. & Rouse, Winslow, "The Use of Department of Corrections Reception Centre Diagnostic Services By California Superior Courts Under Section 1203.03 P.C. From 1957 to January 1, 1963." Unpublished paper. p. 1.

solve the problem of the mentally ill offender regardless of what group you classify as ill, it will in the end backfire." (1)

1. Choate, C. Arthur, Letter to the writer. 31 January 1964.

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A SURVEY OF SOME REPRESENTATIVE CLINICS
IN CANADA AND THE UNITED STATES

by

GORDON LAVERN McPHERSON

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1964

The University of British Columbia

CHAPTER III

A Survey of Some Representative Clinics in Canada and the United States

Toronto Psychiatric Hospital - Forensic Clinic.

Massachusetts Court Clinic Program. Los Angeles County Probation Department - Psychiatric Clinic. Legal Psychiatric Services - Department of Public Health, District of Columbia. Cincinnati Municipal Court Psychiatric Clinic. Civic Center Clinic, Inc., New York. Psychiatric Institute of the Municipal Court of Chicago. Allegheny County Behavior Clinic, Pittsburgh, Pennsylvania. Implications of the Survey for Correctional Policy.

CHAPTER III

A Survey of Some Representative Clinics in Canada and the United States

One of the purposes of this study was to seek and examine information on existing forensic clinics, to discover when and by whom they were established, who administers them, their function and the services offered, and the clients served.

It was Henry Brooks Adams who wrote, "all experience is an arch to build upon." What may be learned from an examination of these clinics may lead to some answers to certain important questions. The intention is not to suggest slavish imitation. But at least we can learn from their mistakes, and at best build upon the many exemplary things they are doing.

The names of the clinics consulted were obtained by writing to the National Council on Crime and Delinquency requesting a list of forensic clinics in operation in the United States of America. The list received in response to our request contained the names of eight clinics in the United States and one in Canada. It is not known how complete this list is; although the presumption would be that there would be few such institutions, if any, whose existence and work were unknown to so authoritative a body as the National Council on Crime and Delinquency. In any case, the list is almost certainly representative of the work being done by the kinds of agencies we are interested in.

III-2

The names and addresses of the clinics are listed below:

Toronto Psychiatric Hospital - Forensic Clinic,
7 Queen's Park Crescent, Toronto 5, Ontario, Canada.

Massachusetts Division of Legal Medicine (Department
of Mental Health),
33 Broad Street, Boston, Massachusetts.

California - Los Angeles County Probation Department -
Psychiatric Clinic,
1605 Eastlake Avenue, Los Angeles, California.

New York City - Psychiatric Clinic of Court of Special
Sessions,
100 Centre Street, New York City, New York.

Washington - District of Columbia Department of Public
Health, Division of Psychiatric Services, United States
Courthouse, 3rd and Constitution Avenue, N.W.,
Washington, D.C.

Cincinnati Municipal Court - Psychiatric Clinic,
City Hall, Cincinnati, Ohio.

Baro Civic Center Clinic,
44 Willoughby Street,
Brooklyn, New York.

Chicago Municipal Court - Psychiatric Institute,
City Hall, Chicago, Illinois.

Pennsylvania Allegheny County Quarter Sessions Court -
Behavior Clinic,
636 County Office Building, Pittsburg, Pennsylvania.

A letter was mailed to the directors of the clinics named,
advising them of the purpose of this study and requesting copies
of the annual reports, if such were compiled, and any other
information that they felt free to supply concerning their
clinic's program. We were highly gratified with the response
obtained, for eight of the nine clinics replied. The material

received varied in amount, but all the clinics that compiled annual reports supplied us with them. Numerous reprints of periodicals and brochures relating to their clinics were also supplied.

The balance of this chapter will be devoted to a review and summary of the information collected^d from these sources.

Toronto Psychiatric Hospital - Forensic Clinic

The Toronto newspapers, during the winter of 1955-56, blazoned forth with the details of three tragic deaths of children who had been criminally assaulted. They printed numerous editorials and articles decrying rampant sexual perversion. Their continual outcry caused considerable alarm, and led to a state of public concern which resulted in an open meeting being held in Massey Hall in January of 1956 with a panel of four experts, Dr. Ralph Brancale, Dr. Kenneth Gray, Dr. Manfred Guttmacher and Dr. Fred Nostrand. The meeting culminated in a committee being formed; and it was this committee which subsequently recommended the establishment of the Forensic Clinic under the Department of Health for the study and treatment of persons charged with criminal offences, particularly sexual ones.

The Forensic Clinic is an out-patient clinic and is customarily used for the examination and treatment of persons over sixteen years of age who are not in custody. It is maintained by the Department of Health, Government of Ontario,

pursuant to the provisions of the Psychiatric Hospital Act, R-So, 1960, Chapter 315. This Act was amended by adding Section 23, which provides that:

- (1) there shall be a division of the Toronto Psychiatric Hospital to be known as the Forensic Clinic of the Toronto Psychiatric Hospital;
- (2) there shall be a director of the Clinic;
- (3) a judge or magistrate may order any person who is before him charged with or convicted of any offence to attend the Clinic for physical or mental examination, diagnosis or treatment;
- (4) an order under subsection 3 shall not be made until a judge or magistrate has ascertained from the director of the Clinic that the services of the Clinic are available to the persons names in the order;
- (5) the director of the Clinic may in his discretion report all or any part of the information compiled by the Clinic to,
 - (a) the judge or magistrate who made the order
 - (b) an inspector
 - (c) the person examined, or
 - (d) any person who, in the opinion of the director has a bona fide interest in the person examined.¹

¹Forensic Clinic, Toronto Psychiatric Hospital, Fifth Annual Report, Toronto, 1962, p. 8.

The Forensic Clinic is staffed with teams of psychiatrists, psychologists, and social workers. The annual report for 1962 indicated that the psychiatric staff consists of two psychiatrists, three psychiatric consultants and clinical teachers, and four fellows in psychiatry. The psychology department is composed of the chief psychologist and three clinical psychologists. The social service division has a chief psychiatric social worker and three additional psychiatric social workers. There is also a research associate and two research officers. Since the Clinic is part of the Toronto Psychiatric Hospital, the entire consultant, medical and surgical staff of the hospital are available to it.

The objectives of the Forensic Clinic are:

(1) to establish and maintain an out-patient clinic which shall provide psychiatric consultation, diagnosis and treatment for adults (over 16), in Toronto, on behalf of the Courts and Probation Service;

(2) to provide a similar service for other mental health clinics, hospitals and medical practitioners for forensic problems, and particularly for problems of sexual deviation;

(3) to provide similar service for voluntary patients with disorders of sexual deviation;

(4) to provide teaching facilities for the Faculty of Medicine, Social Work and Psychology of the University of Toronto;

(5) to conduct research in the area of sexual deviation.¹

In accordance with these objectives the Clinic is offering services in the areas of assessment and diagnosis, treatment, ~~and~~ teaching and research.

The Ontario Mental Hospital's Act gives the Clinic authority to conduct an examination of the mental and physical conditions of individuals referred by magistrates under Section 920 of that act. The examinations and tests carried out at the Clinic usually require about ten hours. In each case a report is prepared containing the results and is sent to the court from which the person was remanded.

If the person is found to be certifiably mentally ill, a form authorizing transfer to the Ontario Hospital is sent to the magistrate; and if he approves, the transfer is effected.

Ten beds in the Toronto Psychiatric Hospital are reserved for court cases. If it is considered desirable to transfer the person to this in-patient service, a form entitled "The Forensic Clinic of the Toronto Psychiatric Hospital - Authority for Transfer to Toronto Psychiatric Hospital" is sent to the court.

Only a proportion of the cases is considered to be suitable for out-patient treatment, and this is generally arranged by placing the convicted person on probation with the condition

¹Turner, R. B., "The Forensic Clinic, Toronto", The Criminal Law Quarterly, vol. 2, 1959-60, p. 440.

that he attend the Clinic for treatment. The Clinic also sees cases of sexual deviation from other out-patient clinics, hospitals, and community agencies.

If treatment in the form of psychotherapy is recommended in the report, several types are available, including intensive, long term and reconstructive psychotherapy, re-educative and supportive psychotherapy. Group psychotherapy is being employed with homosexuals, exhibitionists and pedophiles. These groups are under the direction of psychiatrists.

The Forensic Clinic has a close affiliation with the University of Toronto and provides teaching facilities for both undergraduate and postgraduate students. Instruction is also offered to other groups such as psychologists, nurses, social workers and probation officers.

Research is undertaken from time to time but the other demands of the Clinic have restricted this program. However, research projects aimed at clarifying the differences in personality between groups of homosexuals, neurotics, and normals, and the relationship of these differences to attitudes toward parental figures to adult sexual behavior and occupational choice, have been carried out.

During the year 1962, there were 326 new patients seen at the Forensic Clinic. Although the majority were pre-sentence cases, about 30 per cent were accepted for treatment. The

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greatest number of new patients was in the age group 16 to 19 years; they totalled 90. The other age groups were distributed in the following manner:

20 - 24 years	- - - - -	66
25 - 29 years	- - - - -	46
30 - 34 years	- - - - -	39
35 - 39 years	- - - - -	34
40 - 49 years	- - - - -	32
50 and over	- - - - -	19

These data suggest that with the increase in age, there is a diminishing probability of a referral being made.

The diagnoses of the new cases placed by far the larger number - 212 out of the 326 cases - in a category described as "disorders of character, behavior and intelligence." Within this classification, 160 persons were diagnosed as having some form of sexual deviation.

Massachusetts Court Clinic Program

Massachusetts has established a state-wide system of court clinics serving both juvenile courts and adult criminal courts. In 1950, the Legislature requested the Department of Mental Health to make a study of the advisability of providing psychiatric services to the district courts of the Commonwealth. Support for this move was forthcoming also from a committee set

up by the Boston Bar Association and the Suffolk District Medical Society that had been studying a similar question for three years. During this period when the whole field was under scrutiny demands were also being made for the establishment of a sex offender's service. A demonstration service was established with the intent of providing (1) examination and advice to the court and (2) provision of in-patient and out-patient therapy. It was arranged that the demonstration service would be set up in the Eastern Middlesex District Court and in the Concord Prison to determine the feasibility of the operation of a separate set of clinics for a specific type of offender.

The experience with this clinic demonstrated two things - that the courts made extensive use of the service thus provided, and that many cases could be better managed by the probation officer and the court through the use of the Clinic. It became obvious also, that the court wished to use the Clinic for many types of offenders other than sex offenders. It was noted that some cases sent as sex offenders were not, in fact, habitual sex offenders; and that other persons originally seen by the court for problems such as drunkenness, assault and burglary, were in fact, chronic sex offenders who happened not to have been apprehended on a sex charge. It became increasingly obvious that a general court clinic would cover the sex offenders and many other

cases as well, while a sex offenders' clinic would leave many sex offenders untreated. The recommendation was made that services be extended to the majority of the courts requesting it, and that services be expanded to include all types of offenders before the courts.¹

The operation of the court clinics was an expansion of the Juvenile Court Clinic, established in March 1949, of the combined Juvenile Districts of Norfolk County.

In the annual report dated June 30, 1963, it is stated that two additional court clinics had been inaugurated during the preceding year, bringing the total number of clinics to fourteen. The court clinic's program is financed and administered by the Division of Legal Medicine, Department of Mental Health. During the year the professional staff numbered forty, being composed of thirty psychiatrists, nine social workers and one liaison officer. This number was made up of full and part-time personnel but it is not clear what percentage are part-time employees.²

Considerable emphasis is placed on the need for good and close relationships between the court clinics and the probation officers. In discussing the juvenile court situation, Judge

¹Ewalt, Jack R., M.D., "Memorandum to Division of Legal Medicine", February 27, 1957.

²Division of Legal Medicine Court Clinics Program, Annual Report, Boston, June 30, 1963, pp. 2 - 3.

Paul K. Connolly states:

The clinic service should be closely associated with the Probation Department. That Department is an integral part of the Juvenile Court. It has two major functions:

- (1) to make a thorough and useful study that the court may have full material with which to make appropriate disposition in a given case;
- (2) to formulate and execute a plan of rehabilitation, using the authority of the court, for these youths who are placed on probation.

It is easy to see then the really constructive need for clinical service is directly within the Probation Office.¹

Similarly the annual report of 1959 declares:

These clinics have continued to prove their worth in decreasing the commitment rates to State Institutions alone, but their greatest value is shown to be the service which they render to probation. As time passes, more and more offenders on probation are receiving psychiatric treatment in court clinics. These are cases which would neither seek, nor be eligible for treatment in any other kind of clinical facility.²

The close relationship with the probation officer^{and} the necessity of having the clinic attached to the court are emphasized also by Dr. D. H. Russell, Director of the program. He states that clinic services which "belong to the court and function

¹Connolly, Judge Paul K., "The Magistrate and the Doctor", Reprint from Juvenile Court Judge Journal, October, 1962.

²Division of Legal Medicine, Court Clinics Program, Annual Report, Boston, 1959, p. 1.

for and within the court" are more effective than those outside the court structures. He further suggests that ". . . the success of the clinic service depends completely upon its close relationship with probation and the mutual respect and understanding which must develop."¹

The specific function of the Court Clinic program is reported to be:

(1) to assist the court, upon referral, in pre-sentence investigation by providing a psychiatric study of the case;

(2) to provide psychiatric treatment within the court setting for certain cases;

(3) to be of assistance to probation officers in their work with probationers;

(4) to provide psychiatric examinations in cases where commitment to mental hospitals is under consideration by the court.

The long-range functions of the program appear to be as follows:

To practice and development, in the court setting, techniques for the treatment of offenders;

To investigate the psychiatric meanings and sources of antisocial behavior;

¹Russell, D. H., M.D., "Progress of Court Clinics in Massachusetts", Journal of Social Therapy, Second Quarter, 1959.

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To train psychiatrists, and other professional persons, that they may provide service to the courts and other penological settings;

To develop, in a co-operative manner with courts, the most productive and effective use of psychiatry within court settings;

To set workable standards for psychiatric services within courts;

To raise the professional level of probation, and to help to increase its efficiency and scope;

To promote consideration of the idea of the impartial professional expert in court;

To foster the liaison between law and psychiatry.¹

The Massachusetts program is the largest state-wide court clinic program in the United States. Through the program's close relationship with the Law-Medicine Research Institute of Boston University, clinics are used as one of the facilities in the program of training in legal psychiatry. Demonstration conferences between clinical and probation personnel are also presented for students of the law school. All the psychiatrists employed undergo an initial period of training and supervision, since court clinic work is considered a specialty in itself.

The statistics for the year ending June 1963 show that 1,472 cases were seen in psychiatric diagnosis and 512 cases received psychiatric treatment. The social workers saw 365

¹Division of Legal Medicine, Court Clinic's Program, Annual Report, Boston, June 30, 1963.

clients in diagnostic interviews and 188 clients were provided casework services. In addition, 404 cases were seen prior to a decision on the question of mental hospital commitment. The Clinic considers this service most valuable since the examination by the Court Clinic frequently obviates costly commitments for observation.

Los Angeles County Probation Department - Psychiatric Clinic

The reply received to our inquiry from the Research Director of the Probation Department took the position that, since their clinic dealt with juveniles only, it would be of little relevance to this study. The function of the clinic was summarized in the following terms:

The Juvenile Hall Psychiatric Clinic studies children who manifest serious emotional or mental problems and provides diagnostic evaluations and recommendations for the guidance of deputy probation officers and the court.¹

Legal Psychiatric Services - Department of Public Health,

District of Columbia

The Legal Psychiatric Services were established pursuant to an Act of Congress of June 29, 1953. It provided for the appointment of a qualified psychiatrist and a qualified psychologist whose services would be available to the following officers to assist them in carrying out their duties:

¹Adams, Stuart, Ph.D., letter to the writer, 2 January, 1964.

(1) in criminal cases, to the judges of the District Court and the probation officers of the District and Municipal Court;

(2) to such officers of the Juvenile Court of the District of Columbia as the Judge thereof shall designate;

(3) to such officers of the Department of Corrections as the Director thereof shall designate;

(4) to the Board of Parole of the District.¹

The Legal Psychiatric Services are a division of the Bureau of Mental Health and are financed and administered by the Department of Public Health. The functions and activities of the Clinic provide for: diagnostic and personality evaluations (about twenty-five referrals a month are received for personality evaluation); diagnostic study and recommendations regarding the handling and disposition of cases; and psychiatric examinations to determine mental competency. A number of referrals are received from judges of the United States District Court for the purpose of determining whether a defendant is mentally competent to understand the proceedings against him. Such examinations generally entail a brief psychiatric examination only.² Treatment in the form of both individual and group psychotherapy, is pro-

¹Legal Psychiatric Services Division, Bureau of Mental Health, Report covering January 1960 to September 1962, Washington, D. C.

²Ibid., p. 3 - 6.

vided by the Clinic on an out-patient basis and also within the setting of the District of Columbia Jail. Treatment and follow-up services are also extended to include significant and interested relatives wherever such therapy is indicated and feasible.

The group therapy treatment is a very interesting aspect of this program. There were three groups, involving twenty-six patients, being conducted at the District of Columbia Jail, two for male and one for female offenders. Members of the groups are inmates who have expressed interest in such therapy and who, in most instances, have a sentence of one year or less remaining to be served or who are eligible for parole within a year. The purpose of the jail groups is to prepare these inmates for release and to develop and nourish in them motivation to continue treatment at the Clinic after their release, in further efforts to achieve rehabilitation. An encouraging response from the patients ^{has} ~~have~~ been reported but it is pointed out that the groups have not been functioning long enough to do follow-up studies, or to assess, in a systematic fashion, the effect of such treatment.

There are also three therapy groups being conducted at the Clinic on an out-patient basis. One group is with males, another with females, and the third is a mixed group consisting largely of married couples. Most of the patients are either on probation or parole, and close co-operation is maintained with

the probation and parole officers. One of the problems here is the irregular attendance of many of these persons, who are poorly motivated because of character disorders. (In contrast, the jail groups involving literally a captive population, show excellent attendance and participation even though attendance is voluntary.) The therapy groups conducted on an out-patient basis are held in the evenings so as not to interfere with the employment of the clients involved.

Individual psychotherapy is provided on a bi-monthly, weekly, or bi-weekly basis. Again, most of the people served are on probation and parole. The workers at the Clinic find that close co-operation is needed with the probation or parole officers in keeping the patients involved in treatment, especially during the initial period when the patients are frequently lacking in strong motivation and are not involved in therapy. These experiences suggest that it is often advantageous if treatment is made a condition of probation as a help in sustaining and bolstering the patient's expressed motivation.

Consultation services are provided to authorized referring agencies and the Chief Clinic Psychologist also meets weekly with the staff of the District of Columbia Employment Counselling Service for case and problem-oriented consultation and training. To help ex-convicts to find work, a psychologist meets each week with the offenders to teach them, through

psychodramatic techniques, how to avoid the mistakes they would be likely to make in job interviews and other employment situations.

The Clinic provides training for students in clinical psychology and psychiatric social work. Psychology students are accepted at the beginning Externship level and the more advanced Internship level. The training involves intensive diagnostic and personality evaluations utilizing psychological tests and interviewing techniques, closely supervised individual psychotherapy, and participation as observers in group therapy. There is also orientation in and exposure to the role of the clinical psychologist in forensic matters. Social work students may be assigned to the Clinic for their second year field work placement.

There is also training for the staffs of referring and other agencies. Probation and parole officers have been trained to conduct group counselling. The results have been very gratifying, with more than two hundred parolees and probationers now enrolled in the twenty-two counselling groups conducted by these officers. One of the doctors from the Clinic staff provides regular consultation and supervision for these groups. The training program has also included seminars and lectures for lawyers of the Legal Aid Division of the District of Columbia and legal interns from Georgetown University Law School.

The staff of the Clinic give many public lectures, as well as presenting papers before professional groups whenever time permits.

A limited amount of research is done. At the present time work is being done on a study of various character disorders in an attempt to differentiate and distinguish the Anti Social Reaction (Psychopath) from other personality disorders.

The Clinic staff consists of four part-time psychiatrists and two psychiatric consultants working a total of 94 hours a week; two full-time and one part-time clinical psychologists, (90 hours a week); and one full-time psychiatric social worker, (40 hours a week).

The number of referrals received for the year 1961 was 305. The nature of offences and numbers involved were as follows:

Acts of hostile aggression-----	105
Offences involving theft-----	91
Offences involving deception-----	45
Sex offences-----	31
Narcotic law violations-----	29
Miscellaneous-----	41
Charges not stated-----	3 ¹

The total exceeds the number of referrals as several offenders were charged with more than one offence. There were 146 patients seen in treatment from January 1961 to September 1962.

Cincinnati Municipal Court Psychiatric Clinic

In response to the Municipal Court's request for a facility to examine and refer emotionally ill defendants for appropriate

¹Ibid., Table V, Appendix IV.

treatment, the Municipal Court Psychiatric Clinic was ordained by City Council and opened in 1957. The Clinic was actually a continuation of a local scheme for the creation of facilities to deal with a number of such medico-legal problems. The first was an alcoholism clinic opened in 1951 as a joint project of local industry and the Department of Psychiatry of the College of Medicine. The budget for operation was donated by industry and as it became a demonstrable success, the city assumed responsibility for its budget. The Court Clinic was the next psychiatric facility added, and three further services have been added since.

To facilitate administration, a Division of Mental Health comprising these five facilities has been established within the Board of Health. Each facility, or "section", has a Medical Director who is responsible to the Director of Mental Health for carrying out its program.

The Municipal Court Psychiatric Clinic is primarily a diagnostic and referral center. To this Clinic the Municipal Court judges refer defendants with emotional problems that may have led them to commit a misdemeanour. The Court Clinic team of psychiatrist, psychologist, and psychiatric caseworker evaluates the patient in order to understand the past and present social, psychological and medical problems, and identify events that may have prompted the patient to commit his crime. The

findings of the team are discussed in diagnostic conferences, and recommendations are made to the judges about how the patient can best be helped, from the team's point of view. Then at the judge's direction, the Clinic carries out any referrals the judge deems appropriate, these referrals being to community resources that can provide the most appropriate treatment. The Clinic and Probation Department are located in the same quarters and the two facilities work very closely. In fact, the Clinic's chief caseworker is the permanent morning police court representative both for the Municipal Probation Department and the Court Clinic. The chief caseworker is also the supervisory probation officer; he integrates the findings of the Municipal Psychiatric Court Clinic's diagnostic conferences with the Municipal Probation Department's investigation in order to obtain the best possible probation or agency help. The Clinic provides a daily check of the city's jail for disturbed offenders and also a daily screening of the police court docket for known offenders.

The Court Clinic itself has a small counselling center where the usefulness of various techniques for treating and counselling misdemeanants are currently being explored. During the year 1961, treatment work at the Clinic totalled 300 hours, 110 being treatment hours by psychiatrists, 81 treatment hours by caseworkers, and 109 treatment hours by psychologists.

The Court Clinic has published papers in such areas as administrative psychiatry, the diagnosis and treatment of shoplifters, and the referral, treatment and psychology of alcoholics. Research in progress includes epidemiological, social and psychiatric studies of severe criminal categories.

The annual report for the year 1961 shows that the personnel of the Clinic staff consists of two part-time psychiatrists, two part-time psychiatrists in training from the University of Cincinnati, two and one-tenths caseworkers (there is no indication of how many hours of work are required to constitute one-tenth of a caseworker), one psychologist and two full-time secretaries. Two (four hour a week) volunteers serve as research assistants and another volunteer charts the reports for the Social Service Exchange, the Bureau of Identification and the Bureau of Records.¹

During the year, 686 defendants were referred to the Municipal Court Psychiatric Clinic. The offences committed by the defendants numbered 766 and consisted of 56 different types. The 13 most frequent offences committed and the number of times committed were petty larceny, 143 times; disorderly conduct, 126 times; assault and battery, 96 times; drunk and habitual drunk, 90 times; abuse of family, 63 times; child neglect, 35 times; indecent exposure, 31 times; driving while under the influence,

¹Cincinnati Municipal Court Psychiatric Clinic, Annual Report, 1961, p. 21.

20 times; reckless driving, 17 times; obscene discourse, 14 times; vagrancy, 13 times; malicious destruction of property, 12 times; and exposure of person, 10 times.¹

Civic Center Clinic, Inc., New York

The Civic Center Clinic formerly known as BARO, (The Brooklyn Association for Rehabilitation for Offenders Inc.,) was established on a voluntary basis by a group of psychiatrists, psychologists and social workers who decided to establish an experimental psychiatric clinic for the diagnosis and treatment of offenders. There were three compelling forces in its creation: first, hospital clinics were rejecting offenders for treatment; second, the treatment of offenders requires a special type of competence which most psychiatrists and others, no matter how well-meaning, did not seem to have, so that it was necessary to provide a setting in which psychiatrists, psychologists and social workers could obtain this specialized training; and third, even when competent psychiatrists were available, the offender patients, most of whom came from the lower social economic groups, could not afford to pay for the service.

For about three years the Clinic worked on a limited budget with all of its personnel working without pay. Since 1956, the

¹Ibid., p. 25.

New York City Community Mental Health Board has granted support on a 50/50 basis and professional help is now paid for in the form of fees per session. In April 1954, the Clinic was approved by the New York State Mental Hygiene Department and the New York State Department of Social Welfare and was duly licensed as an accredited psychiatric facility. By the end of that year, it had been approved by the New York City Health and Welfare Council of Greater New York.¹

The Civic Center Clinic is a voluntary agency, independent of any legal or quasi-legal organization. Its Board of Trustees consists of judges of various courts in New York City, representatives of the New York Board of Education, prominent business men, union officers, social workers, attorneys, and others. In addition, the Clinic has a psychiatric advisory board of twelve doctors. The Clinic is open on Saturday mornings and on Monday, Tuesday and Wednesday evenings to serve those patients for whom the regular weekday hours would conflict with work commitments.

The Clinic uses a team approach comprising psychiatrists, psychologists, psychiatric social workers, neurologists and vocational guidance counsellors. Diagnosis and recommendations are made as a result of the interchange of ideas at the group conference on each case.

¹Tropp, Sol, "The BARO Civic Center Clinic", N.P.P.A. Journal, New York, vol. 5, January, 1959, pp. 44-52.

Anyone over sixteen years of age and residing in New York City is eligible for Clinic service and referrals are accepted from the Criminal Courts, private and public agencies, responsible members of the community, families of offenders, and by self referral. However, since February, 1959 an Admissions Committee composed of the Medical Director, the Administrative Assistant to the Director, a senior psychiatric social worker and a certified psychologist, has been established. They review all referrals to establish whether the clients will be accepted for diagnostic study, with the ultimate goal of treatment. The only exceptions made are the cases referred by a court requesting the Clinic to do a psychiatric study before sentence is passed. Previously, when the Clinic had accepted all referrals, the waiting list became very long and many patients became discouraged and dropped out. It was felt that many on the waiting list might be accessible to treatment if they could be seen quickly, whereas a delay of a few months without any help might result in further difficulties. Through the Admissions Committee there has been a great reduction in the backlog of cases which has helped considerably in retaining those patients who were motivated for treatment. It has also been instrumental in cutting down the tremendous cost in diagnostic services to those patients who were not amenable to treatment and had poor potential for such diagnostic services.

Each person accepted for clinic service is submitted to an electro-encephalogram examination and a diagnostic process that includes intake screening, intake interview with patient and family, physical examination, laboratory workup, psychological examination, psychiatric examination, staff conference, summary report and disposition interview.

The following treatment methods are employed by the Civic Center Clinic:

A) Individual therapy is undertaken by the psychiatrists, certified clinic psychologists and experienced psychiatric social workers. The psychologists and social workers are supervised by a senior psychiatrist.

B) The Clinic has undertaken treatment using the group process for:

1. a heterogeneous group which consists of offenders who have been involved in a variety of offences, including those related to sexual deviation or drug addiction;
2. sex deviant groups of which the Clinic at present has two, made up respectively of homosexuals and those involved in exhibitionism and voyeuristic offences;
3. a drug addict group with which the Clinic has been experimenting, using group counselling and

guidance on a long-term basis under the administration of social workers but with psychiatric consultation;

4. family counselling, where a program of working with family members of patients has been set up in order to relieve the patient of pressures to which he might be exposed because of family conflicts.

C) In some cases, use has been made of a combination of individual and group therapy whereby many patients who are in treatment at the Clinic are involvedⁱⁿ both ~~in~~ above types of program, if in the judgement of and upon the recommendation of the senior psychiatrist, there appear to be clinical grounds for such a procedure.

D) Chemo therapy where the use of tranquilizers and steroid therapy is accompanied with individual or group therapy, such treatment being undertaken only by the psychiatric staff members of the Clinic.

E) Vocational guidance and counselling is provided by graduate students from the local University under the supervision of an authority in vocational guidance and counselling.

F) Remedial reading and programs are operated ~~from~~^{for} those offenders whose rehabilitation is thought to be bound up with the ability to overcome serious reading disabilities.¹

¹Services and Activities, Civic Center Clinic Inc., New York, Memorandum dated July 2, 1962.

The Clinic also carries on a limited amount of research. At the present time, a project is being considered with the drug addict group, and another in the field of organic disorders. The Clinic provides a course in group guidance and counselling which is given for professional people who, for the most part, are graduate students in social work or psychology. In 1962, the Clinic offered two series of seminars and consultation services for probation officers, parole officers and others engaged in the field of delinquency. The Clinic attempts to do an educational job outside the agency by speaking to various groups and pointing out the need of psychiatric treatment of the socially disabled.

The annual report for the year 1962 shows that 357 cases were processed. Of this number 321 were males and 36 females, with 108 cases for diagnosis only and 249 for diagnosis and therapy. The most frequent offences committed were sex offences, followed by offences against property, drug offences and offences against persons.¹

Psychiatric Institute of the Municipal Court of Chicago

When the City of Chicago is mentioned, most people associate with it the reputation for lawlessness and criminality that was bestowed upon it by Al Capone and the gangland wars. However, of the clinics reviewed, Chicago's was the earliest established,

¹Civic Center Clinic, Inc., Statistical Report, Brooklyn, 1962, pp. 1 - 6.

having been founded in 1914 as an agency of the Municipal Court. Its primary function is diagnostic, the Institute serving as an out-patient clinic examining adults referred by the Municipal Court Judges, by the Social Service Department of the court and by the House of Corrections. A move was made in 1963 to undertake treatment in certain categories. There was a delay in the initiation of this program because of the loss of numerous key staff people and the resulting necessity of recruiting new staff. However, with the aid of consultants from universities and out-patient clinics, a statistical study of cases going through the Institute considered amenable to treatment was undertaken. The Clinic's position is that its work is so unusual that even when well trained people are obtained, if they have not had previous experience in a similar setting, a training period of at least three months is necessary before they are able to function without extensive supervision.

The Clinic also trains psychiatric residents and students in psychology and psychiatric social service from the local universities. Loyola University has placed with the clinic a faculty supervisor from the School of Psychiatric Social Service Administration; and the Clinic staff has been closely involved in the training and treatment program initiated in this manner. Also, in cycles of three months, they have undertaken a one day

per week training program for Psychiatric Residents from Northwestern University, Chicago University, the Veteran's Administration, the Institute for Psychosomatic Medicine of Michael Reese Hospital and others in groups of four to six residents. There are plans too to organize a psychology program with the University of Chicago which will involve in-service treatment training for a psychologist working toward a Ph.D. degree.

The common "psychiatric team" approach is used by this Clinic also, with each patient first receiving a thorough study, including psychiatric and psychological examinations. In making the diagnosis a psychiatric social history is completed, and statements from the complainant and the arresting officers and reports from other agencies are utilized. Special examinations and clinical tests are made in complex cases. The diagnoses and recommendations are then reported to the referring judge.

A branch of the Psychiatric Institute is located at the House of Corrections. The Clinic was able, near the end of 1962, to obtain additional space at the House of Corrections and by this means was able to double the numbers of its diagnostic staff working there. The greatest advantage that the Clinic finds in having a branch located in the House of Corrections is that the institutional service provides more control in scheduling examinations. This in turn, permits more time at the main office for other essential clinic functions.

The staff of the Psychiatric Institute has to be relatively large to handle the seven thousand cases or more that are culled from many thousands of hearings which annually come before the Municipal Court of Chicago. The Director's report listed forty-three staff members composed of psychiatrists, clinical psychologists, psychiatric social workers, electro-encephalographic technicians and office employees. There was no breakdown in the numbers of each.¹

The annual report shows that alcoholism, domestic discord and sex offences again led the causes for arrests and in that order, with alcoholism often a significant factor in the other two categories of offence. Primary alcoholism was present in 876 cases and secondary alcoholism (a contributing factor in patient's difficulties) in 1,939 cases. Sex offenders examined totalled 751. During the year 7,132 cases were referred; there were 338 cases pending from December 31, 1961 and 304 cases pending from December 31, 1962. Thus, 7,166 cases were completed in the year 1962.²

The recommendations made by the Institute on cases referred to it are distributed as follows. Twenty-five per cent are

¹Kelleher, E. J., M.D., Director, "The Psychiatric Institute of the Municipal Court of Chicago", 1963.

²The Psychiatric Institute of the Municipal Court of Chicago, Annual Report, Chicago, December 31, 1962, p. 2.

certified to Cook County Mental Health Clinic. These are mainly persons with schizophrenia, manic depressive psychosis, paranoid disturbances, organic brain conditions or chronic alcoholism. Fifteen per cent are referred for private psychiatric care or private clinic treatment. These include psychoneurosis, anxiety conditions and other problems treatable outside an institution. One per cent are committed to Dixon State Hospital as mental defectives. Twenty-five per cent are returned to court with no specific psychiatric recommendation. These are persons whose examination shows them to be essentially normal, reacting to temporary, situational stresses, or otherwise presenting no psychiatric condition affecting the particular offence for which they are under trial. Thirty-four per cent are returned to court with various other recommendations such as marital counselling, Alcoholics Anonymous or probation.

The specific recommendations made on the 1962 cases were: committed to mental hospitals, 1,729; committed to schools for feeble-minded, 16; psychiatric treatment in clinic or office, 608; neurological clinic treatment, 35; home for aged or infirm, 17; Chicago Alcoholic Treatment Center, 16; Correctional Institution, 135; no psychiatric recommendation, 2,379; multiple recommendations such as Alcoholics Anonymous, probation, court

surveillance, marital counselling, 2,321.¹ These statistics show that the Institute removed approximately 1,800 defendants from the courts and the House of Corrections to mental hospitals, schools for mentally retarded or homes for the infirm, thereby protecting the individual and the community from possibly further anti-social acts. In addition, the Institutes' referrals to social agencies, marital counselling, office or clinic psychiatric treatment, or Alcoholics Anonymous involve approximately 2,900 more referrals. One very important end result in this work is the reduction of the rate of recidivism before the courts.

Allegheny County Behavior Clinic, Pittsburgh

The Allegheny Behavior Clinic, founded in 1937, is part of the Court of Quarter Sessions. It was promoted largely through the efforts and interests of the late Judge Ralph Smith and the first chairman of the Behavior Clinic Committee, the late Judge James Gray. Through their efforts, a committee of lay and professional people was organized to study similar existing clinics throughout the country. Their study culminated in the founding of the present clinic.

There has been little change in the Clinic's organization, function and purpose since its founding. The Committee, in its

¹Ibid., p. 1.

original study, adopted certain principles as operational policy and procedure which have been fairly consistently adhered to every since. These may be summarized as follows.

(1) It is not feasible or necessary to examine psychiatrically all defendants lodged in the county jail and held for court. To do so represents a waste of time, money and facilities.

(2) Particular offenders should be examined routinely. Sexual offenders are included here because of the obscure psychopathological conditions so commonly encountered in this kind of case. The Clinic has examined routinely every sex offender in the Allegheny Court since 1937, with the exception of cases of fornication and bastardy. Later, in 1955, it was decided to examine routinely all cases of arson and homicide. Other types of cases have always been examined selectively when there was some special reason for doing so, and these have usually consisted of crimes against persons rather than those against property.

(3) The examination should be voluntary, pre-trial and only on cases held for court. After a conviction of a varying number of cases, which would ordinarily not be examined routinely, are remanded by the presiding judge for limited or total evaluation. Deferring sentence and remanding for evaluation has proved to be of special value when the defendant suffers from a serious physical illness, is psychotic or insane, or is mentally retarded or feeble-minded. In practice, the Clinic has developed

such close liaison with the personnel of the County Jail that most of these cases are detected and examined prior to trial.

(4) The information obtained from the defendant shall be considered privileged, confidential, medical information, and as such not available to anyone but the presiding judge and then only after conviction and guilt have been established.

(5) The Clinic shall avoid participation in trial procedure. The defendant should be tried by evidence and not by medical or psychiatric testimony. Once guilt has been established, however, the Clinic staff can testify in the matter of mitigation or aggravation.

(6) The Behavior Clinic, being organized with a small and numerically constant staff, should accordingly limit its case-load. The Director should avoid exceeding staff capabilities unless the Clinic, like so many other public facilities should decline into a "paper operation".¹

The Behavior Clinic is not a treatment facility. Its responsibility is complete evaluation, diagnosis and recommendation. Its purpose is to provide the judges with a better understanding of the guilty defendant so that sentence or punishment will be more meaningful and useful to the defendant and

¹Davis, E. H., M.D., "The Purpose, Organization and Function of the Allegheny County Behavior Clinic", Pittsburgh, October 25, 1961.

the community. The procedure followed in the Allegheny Clinic is unique in that complete psychiatric, medical, psychological and social studies are done on selected defendants before trial with their attorney's consent. The findings of the Clinic are summarized and forwarded to the presiding judge in a sealed envelope. If the defendant pleads guilty or is found guilty, the judge may open the envelope and make use of the information for any purpose he deems useful. If a verdict of not guilty is rendered, the sealed envelope is returned to the Clinic and is not made available to anyone. The Clinic emphasizes that it does not function for either the prosecution or the defence, and that neither prosecution nor defence has access to the Clinic's records prior to conviction. The information is considered confidential and is for the benefit of the presiding judge in passing sentence. In those cases where the examination indicates that the defendant is not responsible for his behavior and not competent to stand trial, the Clinic immediately notifies the District Attorney's office and the defendant's family and his attorney, so that appropriate action can be taken to have the defendant committed to a mental hospital for treatment.

The Behavior Clinic is under the jurisdiction and supervision of a Behavior Clinic Committee selected from the County Board of Judges and is composed of four judges with one being the

President of the Board of Judges. There is also a professional advisory committee consisting of four physicians, a psychiatrist, an attorney and one social worker. This committee is available in consultation on difficult problems of professional standards, personnel and procedures.

The staff consists of a director who is a physician and certified psychiatrist, an assistant director who is a physician and certified psychiatrist employed part-time, a psychologist, two psychiatric social workers, an administrative assistant who serves as a liaison representative between the Clinic and the court, three stenographers, a file clerk and two consultant psychiatrists who, at the discretion of the director, can be called in on consultation in especially difficult cases.

Since 1937, the Behavior Clinic has examined over 13,000 defendants. These are largely sex offenders, but the Clinic throughout the years has accumulated a tremendous amount of case material on almost every type of offender. There have been in that time over 270 murder cases and approximately 130 cases of incest. The Clinic has, for many years, maintained a teaching program through the University of Pittsburgh Medical School. Each month two senior psychiatric residents and physicians from Western Psychiatric Institute are assigned to the Clinic where they study its function and participate in the study and evaluation of particular offenders. Recently, senior law students

from the University of Pittsburgh have been included in this teaching program.

Implications of the Survey for Correctional Policy

A) It is difficult to synthesize from the information reviewed the main trends and common features of these seven clinics. It is, of course, evident that their programs vary considerably in respect to size, length of time they have been in operation, and range of services offered. However, all the clinics reviewed did have three major program objectives: they provided services for the courts, they were centers for teaching, and they engaged in research, although what they offered even in these three common areas was by no means uniform.

B) The statistics disclose that the diagnostic functions far out-shadow the service provided in treatment. Two clinics provide no treatment whatsoever, while one has instituted in the past year a statistical study to find what cases passing through its hands would be amenable to treatment if it were undertaken. Out of four clinics reporting treatment as a service, three indicated that thirty per cent or less of all patients seen were provided treatment. The clinic showing the most explicit commitment to treatment was the Civic Center Clinic of New York which is a voluntary agency, independent of any legal or quasi-legal organization. It also has an Admissions Committee which is stringently selective about the patients the Clinic will accept

for diagnostic and treatment services.

C) One of the problems that Mr. W. T. McGrath, Secretary of the Canadian Corrections Association, suggested as a point of contention was the question of whether a clinic should be under the administration of the Attorney General's Department or the Department of Health.¹ Little light is thrown by the present survey on this problem, if such a problem in fact exists; for of the eight clinics reviewed, four were under the administration of health departments, three were court agencies and one was a voluntary agency. There is no indication, that can be noted, that any special difficulties arise from being under the jurisdiction of one rather than the other. The importance would appear to be in the difference between being under the court and for the court. There needs to be a close relationship between the clinic and the court for the service to be most effective.

D) It is obvious from the clinics reviewed that there is considerable merit in establishing clinics even if in a small way. There is a need for the application of psychiatry in legal problems to assist the courts in sentencing, to help the probation officers manage their caseloads and in providing other treatment.

E) To routinely examine all defendants held for court would be a waste of time, money and facilities. The great major-

¹McGrath, W. T., interview with Mr. A. Byman, November, 1963.

ity of adult offenders are not in need of psychiatric and ancilliary services, however, about one out of every twenty convicted is in need of these services.

F) There is a need for routine examinations of some offenders, especially those involved in offences against persons, sex crimes and arson. These are often offences that are hard to understand and may be indicative of a psychotic or other psychologically determined offender.

G) The Massachussetts Clinic's experience provides us with a case against confining the work of a clinic to sex offenders. They found that some cases referred to the clinic as sex offenders were not, in fact, habitual sex offenders and that other persons seen by the court for other problems were, in fact, chronic sex offenders but had not been apprehended on a sex charge.

H) One of the treatment services provided by the Civic Center Clinic is remedial reading. They find that a substantial portion of the offender population has a reading disability, and and thus they feel it is a vital service in working with many of their patients. This provides us with a caution against stereotyping the services to be provided by a clinic, and should keep us alert in endeavoring to provide services to meet the various needs.

I) The use of different technicians and volunteers by some of the clinics with effectiveness, provides a case against restricting the range of disciplines and personnel utilized. Psychiatrists, psychologists and social workers are the obvious disciplines and are essential but this does not mean that we should exclude the others.

J) It is important to have within a community a range and quality of facilities to meet its particular needs. They are essential in complimenting the services of the court clinics and in providing resources for treatment. The Cincinnati Municipal Court Psychiatric Clinic is one phase of a planned program by the City of Cincinnati in developing several services to meet the needs of its citizens.

K) It is interesting to note that all clinics providing treatment are making use of group therapy to some extent, and the clinic in Washington, D.C., in particular, appears to have an extensive program whereby they are training probation and parole officers to work in this area under supervision. Since so many of the persons becoming involved with the law and referred to the clinics are diagnosed as suffering from character disorders, it would appear that more treatment should be on a group therapy basis. The majority of these people can obtain little profit from intensive "uncovering" therapy. They would seem to be more

amenable to sociotherapy than to psychotherapy and will often respond more to group pressure and milieu therapy. For many, there also seems to be a need for understanding and support which it would be feasible for the well trained probation officer to provide in a supportive treatment program.

L) Probation has been defined as "the eyes, ears, arms and legs of the court", and it is essential that a close relationship be maintained between the court clinics and the probation officer. He is usually considered the "third party", a member of the clinic team.

M) In establishing correctional policy for an individual clinic, it is necessary to keep in mind its size and the services it can adequately provide. If the caseload is not limited to staff capabilities, it will deteriorate into a "paper operation".

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THE FORENSIC CLINIC

Some Considerations regarding the
Structure and Function of an
Ideal Forensic Clinic

by

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Recent years have witnessed an encouraging expansion in probation and parole services and a proliferation of different types of correctional institution in this country. The time thus appears ripe for setting up an agency which can provide authoritative leadership in the scientific study of criminal behaviour and thereby give guidance to courts and other agencies in the tasks of rationally determining the diagnosis and treatment of the offender.

In this chapter, that agency (the forensic clinic) will be described in what may be called "ideal" terms. Its staff, programme and mode of administration, as they each relate to its function, will be indicated. Preceding chapters of the thesis have outlined the need and rationale for such an agency. A later chapter will deal with problems associated with the establishment of such an agency in British Columbia.

Some discussion of the name of the organization envisaged seems to be appropriate. Its function of diagnosis and assessment for court and probationary services suggests the title "Forensic Clinic", but the need for research and training of treatment personnel for the correctional field would make the term "Institute" more appropriate. As a compromise the appellation "Forensic Centre" might be acceptable. The Centre would provide facilities for the observation and study of criminal pathology as well as diagnosis and treatment of certain types of adult offenders with mental or behavioural abnormalities. In addition, sociometric studies of delinquent and criminal groups would be undertaken. Thus the Centre would fill the present need for a general type of clinic, dealing with many types of crime, the resources of which would be available to all appropriate

agencies, whether public or private.

The function of the Centre would fall under the following headings:-

1. Diagnosis and Assessment.
2. Treatment.
3. Research.
4. Education.

These functions will be considered separately, but this should not be understood to imply undue specialization of Centre staff. Hugh Klare¹ has pointed out the desirability of having diagnostic personnel involved also in treatment situations so that the one type of work would tend to strengthen the other.

We have found both in remand homes and in classifying schools (i.e. schools where classification only is carried out, if such work could not be carried out in a remand home) that it was important to have treatment facilities attached to diagnostic facilities. It allows the whole procedure of observation to be carried out in a better way; permits more constructive relationships between custodial staff and clients and allows observation of group situations and of the way in which clients interact.

Klare also points out that if any classifying work is done, a good feed-back system is essential

....You must be sure that any classifying work is done in such a way that you have a good feed-back system. Classification presupposes a typology of offenders and of institutions, perhaps related to some treatment rationale, together with constant evaluation of classification methods. This is a very practical aim, for the right selection of offenders for the right treatment methods could improve treatment results. It could also permit controlled experiments.

1. Hugh J. Klare (Secretary, The Howard League for Penal Reform) Corr. dated October 8th, 1963.

1. Diagnosis and Assessment

(a) For the Courts.

The Centre would provide facilities for magistrates and judges of the courts for the diagnosis and assessment of individuals before and after conviction. Included in the report would be a recommendation of the Centre as to sentence and the probable usefulness of Centre treatment services to the individual.

The Criminal Code of Canada gives courts power to remand an accused person for mental examination prior to conviction.² A convicted person may be remanded in or out of custody, and a psychiatric examination might be ordered as part of a Pre-Sentence Report. The mental fitness of persons to stand trial in court would be assessed at the Centre, on referral by the court. Expert opinion would also be available at the Centre on whether or not a person was "insane" at the time of an offence.

(b) For the Probation and Parole Service

The Centre would be able to provide diagnostic facilities to the probation service in assessment of persons on probation after sentence had been suspended by the court. This need of the probation service will always exist since the time necessary for a comprehensive diagnostic study prior to sentence is often either very limited or not available. If necessary, referral to the Centre by the probation officer could be effected under a term of the Recognizance, such as "...to attend such Centre for purposes of diagnosis and treatment as the probation officer may require." These Centre facilities would be available to parole officers in a

2. Criminal Code, Sections 451c; 524(1)(A) and 710(5).

similar way, although in this case, much more adequate information on the offender is usually available on institution files.

(c) For Boards of Parole.

The Centre would be able to advise Boards of Parole, both Provincial and Federal, as to the suitability of inmates of correctional institutions for release on parole. The present reports available to Boards of Parole are compiled by institutional staff and field parole officers. In some cases a more expert and thorough examination of the inmate is required, and this can be requested of the Centre by the Board. Such referral might take place under the following conditions:-

- (i) Where there is a conflict of opinion between institutional and parole staff as to the suitability or readiness of the inmate for parole.
- (ii) Where a personality problem exists of greater severity than the institutional or parole staff are competent to assess, especially as regards potential risks to public safety.

The Centre would provide courts with extensive professional studies on persons charged under the habitual criminal section of the Criminal Code. The present legislation with regard to the sentences which can be imposed on habitual criminals places an unusually severe burden of responsibility on magistrates and judges. An expert and thoroughgoing analysis of the convict's reformability, prepared by the Centre prior to the initiation of habitual criminal proceedings, would be of great assistance to the courts.

The Centre would provide consultation when it was necessary to decide whether a person should be classed as a criminal sexual psychopath under the Criminal Code, and give opinion as to the fitness for parole of persons already so classed. This area of penology is one which calls most particularly for that type of dispassionate, scientific examination which a Centre would be able to offer.

The diagnostic assessments outlined above might involve interviews with psychiatrists and psychiatric social workers, psychological testing, electro-encephalograph, X-Ray, endocrinology and other examinations. Relatives and close friends or associates of the subject might also be interviewed, and material for a social history thereby gathered. Other studies which might form part of the Centre's work include somatotype assessment, and genealogical and genetic investigations aimed not only at exploring hypotheses about the inheritance of mental characteristics but also at obtaining a fuller understanding of the individual offender.³

3. In case the nature of this recommendation remains unclear, it should be said that we are speaking here of studies which would be part of the Centre's diagnostic work, and not of a separate body of topics for research. It is imperative to recognize that -- just as crime prevention and control programmes must be concerned with social structures as much as (if not more than) with personalities -- so must the processes of "diagnosis", "prognosis", pre-sentence investigation and the like, be informed with a sophisticated awareness of the collective dimensions of criminal behaviour. A forensic centre must of its very nature have a bias toward the endopsychic causes of crime, but it must be careful in indulging this bias to avoid the traditional psychiatric error of acting as though people lived in etiologically neutral environments.

It should also be said that we do not countenance the idea of keeping diagnosis and research in separate compartments. The former

Inquiries into the genesis of prison riots, gang warfare of outbreaks of vandalism and arson would be part of the Centre's concern. The ecological analysis of urban areas from the point of view of the incidence of criminal activity could also be carried out.

An important function of the Centre should be to provide leadership in co-ordinating the activities of the several existing agencies dealing with crime prevention and its treatment. A cross-fertilization of ideas through the use of lectures, panel discussions and joint projects should be an ongoing process in the mobilization of local resources for the intelligent and competent treatment of offenders.

The Centre should come to be seen by the professional and lay public as the locus of the most expert knowledge and techniques available concerning certain phases of criminal behaviour.

2. Treatment

The following statement concerning the impact of "correctional" experiences on a convicted person gives clear expression to the dangers of professional compartmentalization:-

Although the prisoner, during the whole course of his progress from arrest through conviction to release, may come into contact with many different people, so that no one of them may get a particularly clear picture of the prisoner's experience at other points, it should be recognized that the prisoner himself has a continuous experience and that what happens to him at an earlier phase may critically condition his response to later situations and opportunities. It should be recognized that the whole experience which starts with arrest and interrogation, and passes through trial, sentencing and serving time,

should be organized so as to maintain the data collected in a state of availability for research; the latter should be conceived and executed so as to enhance the value of diagnosis.

determine the prisoner's attitudes and ability to take advantage of rehabilitation on release.⁴

The principle embodied in the above quotation should inform the activities of the Centre staff at all times.

The main drift of contemporary corrections is probably to be found in the fact that a more "scientific" and humanitarian approach is steadily gaining ground over blind punishment and mere custodial care. The Centre would play its own important and special part in the encouragement of this approach in a variety of ways, but mainly, perhaps, through its practical embodiment of the goals of "treatment".⁵

Implicit in the notion of treatment is the conviction that criminal behaviour is often symptomatic of some under-lying psychosocial dysfunctioning. The goals of the Centre would therefore be chosen with a view to helping the convicted person in his basic psychological and social adjustment, thus bringing about a reduction or even disappearance of anti-social and illegal behaviour patterns.

The following classes of persons might receive treatment or advice at the Centre:-

- (i) Adult probationers, persons under suspended sentence, referred by the courts (para. 638 (2) CCC) or by the Probation Service.

4. Forensic and Correctional Services (Committee on Mental Health Services, C.M.H.A., J.S. Tyhurst M.D., Chairman, March 1960.

5. At the same time, we recognize that the very creation of something like a forensic clinic would be an important outcome of the new approach to penology, as well as a vindication of it.

- (ii) Parolees, Federal or Provincial, referred by Federal or Provincial Boards of Parole, or parole officers.
- (iii) Voluntary adult patients, referred by other public and private agencies, as well as by professionals in private practice.
- (iv) Members of the public at large, seeking advice or help for themselves or relatives afflicted with anti-social behaviour patterns.

As far as the method of referral is concerned, it is stressed that simplicity should be paramount. At the Clinic administered by the Brooklyn Association for the Rehabilitation of Offenders, a letter or telephone message from the individual seeking help is sufficient to effect referral; and this procedure would seem an adequate model as far as members of the public are concerned. In the case of official bodies, the procedure at present in use in Vancouver courts seems unexceptionable. Here the court clerk, on instructions from the magistrate or judge, fills out a form on which the following data appear:-

- (i) Name of convicted person.
- (ii) Name of referring magistrate or judge.
- (iii) Type of report required.
- (iv) Date of referral.
- (v) Date the report is required.
- (vi) Location of person convicted; whether in custody, on bail or released on his own recognizance.

The referral slip is passed by the court officer to the appropriate official concerned, generally either the probation officer or court psychiatrist.

This type of simple procedure could be modified for use in referral by other community agencies or "private" professional persons.

Treatment methods at the Centre would include individual and group psychotherapy, and occupational, physical and chemotherapies.⁶ Full legal scope must be available for progressive methods to be employed in the treatment of drug addicts. It is interesting, in this latter connection, to note that medical practitioners are becoming more inclined to treat addicts on a medical basis.

Sexual offenders such as pedophiles, homosexuals⁷ and exhibitionists would form an important group for treatment at the Centre, but a broad classification of offenders should be catered for. The tendency to treat too narrow a range of offenders would be present were the Centre to come under the control of any one profession, such as medicine; and the tendency for the Centre to come under the domination of some one discipline would be

6. It should be noted that the phrase used is "...at the Centre." Where the problem at issue is one of disorganized neighbourhoods, rather than of disturbed personalities, different locations for treatment and different methods of treatment are both needed.

7. It should be recognized that not all sexual deviates are, ipso facto, criminals. There exist powerful arguments, which need not be the concern of this study to adumbrate, tending to show that homosexuals should not fall within the scope of the criminal law.

strengthened if treatment were limited to clinically exotic categories of offender.

The Centre would provide a consultative service:-

- (i) To probation and parole services for individual and group treatment of probationers and parolees.
- (ii) To institutional staffs concerned with the establishment of treatment projects.
- (iii) To community agencies and individuals planning preventive programmes in delinquency areas and depressed urban areas. The trend towards area and local organization in work aimed at solving community welfare problems could profitably and appropriately be supported by the Centre.
- (iv) To private physicians dealing with patients who have criminal records or manifest criminal tendencies.
- (v) To after-care agencies, such as the John Howard Society and the Salvation Army, to improve the rehabilitative efforts of these agencies.
- (vi) To the classification section of the Corrections Branch, where required.

Another community need is for the counselling and re-education of the parents and relatives of those involved in criminal behaviour, and this type of work could be initiated by the Centre staff. It has been the writer's observation, (and it is one which is entirely consistent with common sense) that

parents whose offspring show delinquent tendencies are often at a loss as to whom to turn to for help and advice. The personnel of the Juvenile Court would be a natural and obvious source of assistance, but they are often seen by parents as a threat; whilst other social agencies do not have the staff specifically equipped to deal with such problems. The above consideration holds true of relatives of adults who are indulging in criminal or near-criminal behaviour. In such cases, sources of adequate help are often even more meagre. Here the Centre might satisfy an important need.

The Centre could initiate action to provide courses for the lay public in elementary criminology and the psychology of the criminal offender. The eventual rehabilitation of criminal offenders of all types, in particular those convicted of sexual offences, is largely dependent on an informed public opinion. Present attitudes, compounded of ignorance and prejudice, tend to stultify efforts to help the criminal resume a productive and law-abiding role in the community. Many educational agencies, such as the university proper, fail, for a variety of reasons, to attract members of the lower socio-economic class, whilst the staffs of school systems do not possess the necessary experience in such matters. More advanced courses should be made available to such professionals as lawyers, social workers, medical doctors, police officials and others who might have the need for and interest in such instruction.

3. Research

It is most important that the staff of the Centre possess

attitudes favourable to research. No staff member should be appointed who has not demonstrated a career commitment to some type of research in the behavioural sciences. All too often, research personnel in such institutions as the Centre become isolated from their colleagues and their efforts are rendered ineffective and sterile by the lack of coordination with other agency functions. The Centre Director must ensure that interchange of information and ideas between research and other professional staff is raised to a high level of efficiency.

If it be generally accepted that coherently stated institutional purposes are conducive to good morale in any organization, then the significance of the research goals for staff in an organization with purposes as complex as those of the Centre would be can hardly be over-stated. For professionals in the behavioural science field are, by the nature of their material, particularly susceptible to frustrations engendered by lack of tangible results in their work. Clearly defined research goals would give all the staff a necessary sense of direction and, when achieved, a sense of fulfillment. These desirable by-products of professional work are often absent in correctional treatment and diagnostic situations.

The importance for research of the development of a good feed-back system from the numerous correctional agencies should be stressed. The Centre should take the lead in initiating and sustaining such feed-back procedures.

Although what follows is by no means a definitive list, the Centre should have the resources for carrying out research

concerned with:-

- (i) Collation of natural histories of criminal careers.
- (ii) Assessment of treatment programmes in correctional institutions, within probation and parole services and of Centre treatment programmes.
- (iii) Provision of a library, international in scope, comprising literature on all aspects of criminology.
- (iv) The setting up of research projects to test theories of crime causation and treatment, both at the Centre and elsewhere.
- (v) Provision of staff expeditions to other countries and localities to study the cultural aspects of crime and different methods of treatment.
- (vi) Studies of somatic variables of the kind illustrated in the work of Sheldon, in criminal populations.
- (vii) Genetic studies of criminals.
- (viii) Epidemiological studies.

4. Education

University students in the various disciplines represented by the staff of the Centre, particularly at graduate levels, would receive several types of training at the Centre. This would include field training, workshops in criminal statistics (such as the development of new and sophisticated indices of recidivism), criteria for the classification of inmate populations, and studies on success or failure in probation and parole. Part of the responsi-

bility for the training of correctional officers, including probation and parole officers, should be entrusted to Centre staff.

The Centre should provide leadership in the development of new theories of and fresh approaches to the description and treatment of criminal behaviour. Progress in this field, as in so many other branches of the social and behavioural sciences, requires the formulation of concepts which have the power to organize the scattered observations and insights of which the field now consists; and equally, the effective dissemination of those concepts in those quarters where there is the most urgent need for their use.

The provision of a philosophical basis or rationale for the Centre's programme of activities would form part of the work of its staff, and investigations of this subject would become an integral part of the material for a periodical or bulletin published at the Centre.⁸ This organ might be either of the quarterly type or that known as "Occasional Papers." Another alternative would be an annual, of more elaborate format and containing material international in character. The preparation of pamphlets of use to the lay public in the timely recognition of pre-delinquent traits might also be part of the work of the Centre publishing staff.

8. To say this is not to suggest that questions of this kind are the exclusive concern of a small group of specialists. The administration of criminal justice is obviously a matter which bears closely upon the public interest, and is accordingly a concern to everybody.

There exists at the present time a cloud of ignorance and misinformation concerning crime and the criminal. Specifically and for example, the moral and scientific issues involved in the concept of punishment, deterrence and treatment of the criminal offender remain a source of heated controversy. Consideration should therefore be given by the Centre to the possibility of the use of the mass media (the press, radio and television) to remedy (or, at any rate, improve) this situation. There is no doubt that the staff of the Centre would be admirably qualified, by virtue of their special interests and knowledge, to provide reliable data and valid arguments, but this particular phase of the Centre's work would require the services of an experienced public relations officer. The danger of the Centre's work becoming too heterogeneous and diffuse must, of course, be borne in mind and guarded against.

Centre staff would form a pool of expertness upon which professional bodies working in the field of crime and its prevention might draw. For example, the Centre could provide the facilities and staff for the training of treatment personnel in the field of corrections. At present, in most parts of North America this function is performed by Schools of Social Work and local Departments of Corrections in "on the job" training programmes. The problems of criminal behaviour and its correction are sufficiently complex and diverse to warrant the establishment of a specialized training centre. This facility a Forensic Centre could provide, as has been demonstrated at the New York B.A.R.O. Clinic⁹

9. Sol Tropp, (Administrative Assistant), "The Baro Civic Centre Clinic," "National Probation and Parole Association, vol. 15 (January, 1959).

It should be pointed out, however, that the responsibility for training staff in correctional work and the make-up of that training are still controversial issues. The type of training, for example, which probation officers should receive is itself not clarified. Some probation officers are trained as social workers, others have a Bachelor of Arts degree, and yet others legal training. We do not suggest, therefore, that the Centre's efforts in this matter either could or should be aimed at providing definitive professional education for any group of correctional personnel, but rather at making its own appropriate contribution to the work of continuing education which is generally regarded nowadays as indispensable to the maintenance of competence in any field of professional activity.

Ideally, the Centre should be considered as an integral part of corrections, locally, nationally and even internationally. It would therefore seem logical and necessary for a systematic and regular basis of communication with similar institutions, at home and abroad, to be established. Only thus can progress in the rehabilitation of criminal offenders and the work of social healing be ensured.

The Location of the Forensic Centre.

The Centre should obviously be located in or near the local centre of greatest population density, where it would have easy access to the chief courts and correctional institutions. As the Centre would be carrying out a programme of essentially scientific work through the activities of a highly skilled staff, it would seem

logical that it should be constituted as a department of the local university. It must be remembered, however that the Centre should be both physically and psychologically accessible to non-academic publics, and this consideration suggests that it might be preferable for the Centre to be administratively autonomous. The experience of other agencies in the field, of similar type, should be drawn upon.

As several discrete functions will be performed at the Centre, it appears that separate physical facilities will be necessary. It should also be observed that elaborate physical facilities are not necessarily productive of creative work and that it is better to provide for a high quality staff than a high cost physical lay-out. Where possible, existing buildings might be converted for use by the Centre. The minimum needs for efficient Centre operations must, however, be met. These would include adequate laboratory facilities, sound-proofing in interviewing areas, and the provision of such features as conference rooms, a small film theatre and adequate office facilities. One-way viewing screens for the observation of interviewing techniques and group process must be provided. Residence facilities for voluntary patients should be available.

In some cases, where diagnostic appraisal of an offender has been ordered by the court, the offender is remanded in custody. The question of the location of the custodial unit should be considered. Offenders whose confinement has been deemed necessary by the courts for the protection of the offender himself or the public safety

should be held in existing facilities such as the psychiatric ward of a general hospital, a mental hospital, or a correctional institution. If it is argued that these institutions presently fall short in terms of adequately trained staff, or for other reasons, it must be stated that the work of the Centre will in any case be rendered nugatory unless adequate complementary and supportive services are available in the community. Offenders so confined would have to be transported to the Centre under guard for the purposes of diagnostic examination; or members of the Centre's staff could visit the institution in which the convicted person was being held.¹⁰

Some fraction of the work of the Centre's staff would involve services to parts of the province distant from the Centre itself. The Centre should be as operationally mobile as possible. Small travelling teams of diagnosticians and therapists should make periodic excursions into less densely populated areas. Individual members of Centre staff, notably research personnel, could undertake similar "field trips" from time to time in order to make field surveys of community situations and needs.

The Staff of the Centre.

Among the staff of the Centre might be found graduates from the following faculties: psychiatry, social work, law,

10. The idea of a special remand centre for the examination of convicted persons is not a novel one, especially in work with juvenile offenders. It appears to us that there is an unanswerably good case for the establishment of such a facility for adult offenders too, not only for "scientific" and correctional reasons, but on simple grounds of justice and civility. It is intolerable that a man who has not even been found guilty of an offence should have to wait for days or even weeks in the squalid and corrupt surroundings of the average prison.

psychiatric nursing, medicine, sociology, occupational and physiotherapy, bio-statistics and public administration. The organization should be inter-disciplinary, and the director should be chosen for demonstrated leadership qualities as much as for specific professional qualifications. All the staff should be selected with a view to their capacity for sympathetic participation in the goals and methods of a therapeutically oriented institution, and this should be borne in mind in the selection of non-professional staff members. The ability of staff members to work as part of a team should be ascertained as an integral item in qualification for employment at the Centre.¹¹ All the permanent staff should have had experience in the correctional and/or psychiatric fields. Personnel policies for the staff should be such as to attract the most highly skilled and suitable personnel to the Centre.

In addition to the permanent or "core" staff just mentioned, the Centre staff would comprise graduates seconded from other faculties of the university for specific purposes. There should be no entrenched limitations on the academic or professional identities of those eligible for such appointments. For example, an architectural graduate might well be employed to study court design or prison architecture. Fellowships to various faculty members would be provided where it was felt that this would enhance the work of the

11. We do not mean that they should be "good committee men" -- which is often the last thing that independent and original scientists either aim to be or should be expected to be. But it is true that inter-disciplinary research and practice (difficult enough at the best of times) is almost impossible if those taking part in it are incessantly engaged in impugning each other's intellectual credentials or in manoeuvring for status.

Centre.

The Administration of the Centre.

From the administrative point of view, a considerable degree of operational independence must be allowed for. If a Centre such as the one under discussion were too closely under the control of the judiciary, the professional independence of the Centre staff might be threatened. There would also be the danger, if the Centre formed part of a hospital administration, that it might become too medically oriented and too "institutionalized." The tendency to treat too narrow a range of problems (e.g. sexual problems) would be present. The freer intellectual climate obtaining at a university would probably have the greatest normative congruence with the goals of the Centre.

It is important, however, that the preservation of the necessary degree of autonomy should not prevent a high level of serviceability to the courts, since the principal *raison d'être* of the Centre is the provision of a certain kind of expert judgment in the administration of criminal justice. The organization and control of the Centre must be such as to encourage appropriate and systematic use by the various levels of government; for the jurisdictional boundaries which determine that a man shall be a provincial charge if he is placed on probation or sent to prison for less than two years, and a federal responsibility if sent to prison for two years or more, have little or no connection with the dynamics of his behaviour or his need for treatment.

It would be idle to suggest that there is any simple constitutional expedient or administrative formula by which these problems

can be either eliminated or made less than incorrigibly troublesome. An agency which has to make itself generously available for public service yet maintain the prerogatives of professional self-government is exposed to certain structural and evaluative conflicts which are inherent to its nature. When it is designed for a "clientele" who come under the authority of half a dozen different public bodies, those conflicts are made even more acute. When it must strike some sort of rational balance between routine serviceability and the prosecution of long-term research and educational activities which have no immediate usefulness, it may be wondered if the agency in question can make its way in the world at all. But these are the predicaments of some of our most important institutions:- the "free" professions, Crown corporations, universities, even Members of Parliament. Predicaments may be made manageable even when they cannot be dissolved, and we must hope that the methods by which they are made manageable (intelligent public understanding, skillful improvisation, integrity and good will) would be available for employment in the present instance.

It should be noted that, as is the case with other novel enterprises, the development of the Centre would take place in successive phases. Thus, initial building and staffing should be planned in relation to initial tasks, and these should be seen in the light of the most obvious community needs. The question of how staff are to be selected, whether by a Board of Directors or by the Centre Director himself, will have to be decided upon. Subsequently, the types of work engaged in by the Centre will have to be planned in a logical order.

The Financing of the Centre

It is obvious that a Forensic Centre of the kind described here will be an expensive undertaking. However, the costs involved should be assessed in the light of the scope of the problems faced, and these are patently very great. (For example, Dr. Andre Boudreau¹² speaking on a topic closely allied to the work of the Forensic Centre, is reported to have said that alcoholism has reached almost epidemic proportions in Canada).

The financing of the Centre would have, of course, a great bearing on its overall value to the community. It would be important for the Centre to be assured of continuing financial support to cover sufficiently long periods of time. In particular, research projects undertaken at the Centre would often require periods of time of at least 5 or 10 years to complete. If annual accountability is required, although this would involve tighter control of the use to which available funds were put, the work of carrying out long term projects would be vitiated.

As regards the source of financial support for the Centre, it would appear proper that the Provincial Government should bear the major burden. The Centre would serve the needs of the whole province. The difficult problems of assessing municipal shares in responsibility should be avoided. An argument for the Centre being supported by Federal Grants is available, in that the Centre would provide services to federal institutions. It is suggested that voluntary patients treated at the Centre should pay a fee for such services, or

12. The Vancouver Sun, Wednesday, March 25th, 1964.

alternatively, that a fee be paid on their behalf. The possibility for financial support by philanthropic bodies and foundations should be explored. If the Centre were to come within University administration, the financial arrangements made should be carefully examined, so that the principle of equity as between the various university departments is maintained.

It is evident that there can really be no specification of the character and requirements of an "ideal" forensic clinic centre. For such an institution would have limitless funds, flawless staff members, an envioning penal system which was a model of enlightenment and efficiency, a judiciary which was wholly impartial, incorruptible and competent and a public which was sympathetic and understanding. Presumably, the crime problem would be non-existent! In this case, one alternative open to us would have been slavishly to imitate the administrative structure and "ideology" of some existing clinic, for example the Toronto Forensic Clinic. This clinic, as described in another chapter of this thesis, has undoubtedly contributed much to the field of corrections and has provided a signal service to the urban area it has served.¹³ The present chapter has benefitted from those experiences, both positive and negative, of existing clinics, insofar as their work has been reported upon. It is readily admitted that all such institutions, both existent and projected, will have to perform

13. The variations in the character of crime (drug addiction in Vancouver, for example) as between different regions and ecological areas is, in particular, relevant to the argument.

certain functions, such as the examination of convicted persons on behalf of courts, and our Centre is no different in this regard. Again, it is difficult to envisage a forensic centre whose staff does not include such professionals as psychologists, psychiatrists and social workers, and we have not suggested any such radical departure as the elimination of these. Nevertheless we felt it better to delineate, with some show of reason, the conditions under which such a Centre would need to operate, in order to achieve those tasks it had set out for itself.

The above mentioned line of attack will, it is hoped, provide a type of yardstick by which practical attempts to set up a clinic can measure themselves. Certainly it may be agreed that the setting up of a clinic without careful consideration of its prospects for success or failure would be inexcusable at the present juncture.

Thus it will be noted that some of the most important recommendations that have been made have taken the form, not of concrete specifications of what the "final product" would be like, but of arguments about the way in which the work of the Centre should be approached. For example, the composition of the staff of the Centre has not been catalogued, but suggestions designed to broaden the operational base of the Centre have been made. Again, the way in which the Centre would serve the province in a purely geographical sense has been hinted at in terms of the operations of mobile diagnostic and therapeutic teams; neither the exact frequency of such visits to outlying parts of the

province nor the listing of localities which must be visited have been stated. Thus the recommendations presented might be described as modal rather than definitive.

In conclusion, it would be naive to believe that sensible improvements in the field of corrections generally will come about by the provision of any one or even a number of institutions, however "ideal" they might be. Rather, such progress can only be expected when an adequate philosophy of corrections, which permeates professional and lay correctional circles, helps bring to fruition a comprehensive constellation of facilities, whose concerted efforts are supported by an interested and co-operative public.

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THE FORENSIC CLINIC:

A Proposal for its Establishment in
British Columbia

by

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The need for a forensic clinic⁽¹⁾ in British Columbia hardly needs to be laboured at this point, and will therefore be dealt with here presumptively and briefly. The need for a diagnostic and treatment centre of this description has been stated at some length above. Suffice it to say now that for a Magistrate pondering a disposition on a potentially dangerous sex offender, a Probation Officer in need of diagnosis or treatment for one of his charges, or a medical doctor who believes a problematically deviant patient to be in need of psychotherapy, for these, and many others, a forensic clinic would be of immeasurable value.⁽²⁾

The purpose of this chapter is to outline the method, or methods, which appear most feasible and appropriate in establishing a clinic in British Columbia. Naturally the suggestions made here are not intended to be considered as the only valid approach to the problem, but merely as one which may seem to have its own merits. The most likely problems of the implementing^{of} these proposals will also be considered; but, by the same token, the list of such difficulties should not be taken to imply that all eventualities have been taken into consideration and duly assessed. However, the more obvious problems can be anticipated without excessive difficulty, and some suggestions can be made as to how we might deal with such contingencies.

(1) Although the name used in this chapter is "clinic" it is recognized that forensic centre may be a more appropriate name. Clinic is used in the more conventional sense in this chapter and in no way suggests disagreement with the previous suggestion that forensic centre is a more accurate name than clinic.

It might be advantageous to mention at the outset that it is not suggested that everything requisite to the creation of an "ideal" clinic either could or should be available from the very beginning. It should be recognized that a start of some sort is imperative. If circumstances should make it necessary to begin with a relatively small and experimental clinic, this should be done. To wait indefinitely until all is in readiness for an all-encompassing plan might (and probably will) be fatal. An over-all or "definitive" plan can be drawn up in anticipation of more ambitious programs, but the chances of implementing a modest experimental plan should not be allowed to wither on the vine because the moment for doing something more ambitious is painfully slow in coming.

(2) We are indebted to the following people whose experience and judgment have proven invaluable in the writing of this chapter:

Mr. S. Rocksborough Smith, Director of Correction for
British Columbia

Mr. Stewart McMorran, Vancouver City Prosecutor

Mr. Daryl Jones, Deputy Vancouver City Prosecutor and
now a Magistrate at the Vancouver Magistrates Court

Dr. Guy Richmond, Senior Medical Officer, British Columbia
Corrections Branch

Mr. William McGrath, Executive Secretary of the
Canadian Corrections Association

Given these premisses of practicability it would appear that the time is ripe, if not overripe, for the establishment of a forensic clinic in British Columbia. The recent spate of sexual crimes has roused the interest of the public in the question of devising new and more successful ways of coping with the troubled people who commit these horrifying crimes. The Heathman, Meeker and Hease cases,⁽¹⁾ all coming in quick succession, have graphically indicated the need for immediate and speedy action.⁽²⁾

The interest of the public has most certainly been aroused, and it is surely reasonable to suggest that this interest should now responsibly be exploited in the interest of legislative action. The Toronto forensic clinic was itself started in response to a wave of public concern generated by widely reported sexual attacks on a number of Toronto children. The revulsion and agitation created by these crimes transformed latent concern into action, and the Toronto clinic was thereby brought into being. No doubt

(1) All three cases were before the courts in 1963.

(2) The existence of this need has been proclaimed by a number of responsible public figures. First there is the statement of the Liberal M.L.A., Dr. Pat McGeer who has been quoted as advocating that the Provincial Government should forthwith finance the establishment of a forensic clinic in British Columbia. He has suggested that such a clinic should be staffed with psychiatrists, psychologists and social workers, and has further recommended that the clinic should work in connection with teaching and research facilities of medical schools. To quote Dr. McGeer directly, "It (the clinic) should probe searchingly into our methods of handling psychopaths, particularly sexual offenders...in time it

it is deplorable that the public should need the death of a child to be roused to action; but regardless of the origins of an aroused state of public feeling, its very existence provides an opportunity for social action which might not otherwise be available.

PROPOSED STEPS TOWARDS ESTABLISHMENT OF A FORENSIC CLINIC IN BRITISH COLUMBIA

Insofar as public sentiment is in fact now favourable to the idea, and because the subject is unlikely to be a politically controversial one, the establishment of a forensic clinic in British Columbia might well be found in contacting and interesting certain strategically placed and suitably qualified public figures.⁽¹⁾

should provide us with new and effective ways of coping with an element in our society which we do not understand...it should have its doors open to any individual seeking help..."

One interesting comment Mr. McGeer made was that the clinic should be independent of the Attorney-General's Department. This suggestion can be kept in mind when we are considering how a clinic should be financed and under what administrative auspices it should operate.

Others who have spoken out recently for a forensic clinic are Mr. J. Peter Stein, Assistant Executive Director of the John Howard Society of British Columbia, and Mr. John Fornataro, an Assistant Professor at the University of British Columbia of Social Work. The British Columbia Council of Women in February of 1964 brought forth a resolution which sought assurance that adequate provision would be made for the treatment of sexual offenders and urged the government to establish a forensic clinic as a means of making such a provision.

- (1) It is suggested that this group could avail themselves of a knowledgeable resource person to assist them in philosophical and technical matters pertaining to the establishment of the proposed clinic.

It is all-important that this group of expert and influential persons be convinced of the need for and the feasibility of a forensic clinic, and that they be able to state the case for it to the appropriate officials and the public at large and in an informed, responsible and persuasive fashion.

Who should take the lead in the initial stages of drafting and implementation? This is not an easy question to answer, except by saying that probably any one of several interested groups or individuals could ignite the spark. It could be for example a representative group from the Canadian Mental Health Association or the Canadian Corrections Association. Or again, the incumbent Head of the University of British Columbia Department of Psychiatry,⁽²⁾ by virtue of the relevance and prestige of his office, as well as his personal reputation, would be an inarguably appropriate person to play a leading part in these undertakings. Moreover, a psychiatrist connected with the University would not be in the invidious and vulnerable position of being liable to the charge of having an axe to grind. Although nobody is free of bias of one kind or another, he would at least be a politically "neutral" figure and, at the same time, would not be caught up in the factionalism of inter-agency rivalries.

To specify, in any dogmatically prescriptive fashion, who in fact should be charged with the responsibilities of initiative in this matter would be too particular and circumstantial an under-

(2) Dr. J. S. Tyhurst, who is presently out of the country on a year's leave-of-absence.

taking. It is sufficient, for present purposes, if the general principles involved in the question have been exemplified in what has been said.

The next item in the order of business is to consider who else should be on our hypothetical planning group. This is a question which calls for judgment rather than references for a check list. It would be desirable to get some kind of balance between professional expertness and what may without contempt be called common sense. Moreover, there is a case to be made for including at least one person with a kind of generalized public eminence and reputability that would secure a respectful hearing for the committee's statements which an otherwise indifferent public might not be prepared to accord. This suggestion is made as a way of dramatizing the work of the committee, and not as a device for the manipulation of public opinion.

Certainly the two groups already mentioned (the Canadian Mental Health Association and the Canadian Corrections Association) should be represented. A strong claim might also be entered on behalf of the "local" British Columbia Corrections Association which, though it is affiliated with the Canadian Corrections Association, antedates the national body and has a membership which is likely to be far better acquainted with provincial problems and resources.

It would almost go without saying that somebody from the judiciary should be a member of the planning group. The Courts would naturally constitute one of the principle sources of referral to a forensic clinic, and no realistic plans for the clinic could be made without

reference to their needs and to that point of view which can only be acquired by sitting on the Bench.⁽¹⁾

There is something to be said also for having representation from the British Columbia Council of Women. This organization has expressed an interest in the establishment of a forensic clinic, and its collective opinions are generally accorded respectful attention in official quarters. The fact that its recruitment base cuts across the conventional professional and administrative categories would no doubt serve to carry word of the planning group's activities to an unusually diverse set of "publics".

It is worth mentioning in this connection that several members of the British Columbia Probation Branch have found the support of the Council of Women an extremely valuable asset. On at least one occasion the Council was instrumental in mobilizing support for an important Correctional resource. A suitable representative from this group would almost certainly enrich the composition of the committee.

(1) If nominations are in order at this very early date, it might be ventured that there could hardly be a better representative of the judiciary than Magistrate Gordon Scott, Senior Magistrate of the Vancouver Magistrates Court. The great bulk of referrals would come from the Vancouver Courts and Magistrate Scott's intimate familiarity with the work of these Courts and his own seasoned judgment could well be invaluable. Moreover, he is acutely aware of the needs for a forensic clinic and has a decidedly positive attitude towards the idea of extending the scope of treatment-oriented correctional facilities.

In addition to the Head of the Department of Psychiatry (who act in a somewhat different capacity) there is a strong case for having representation from the University of British Columbia. Two departments in particular come to mind; the Faculty of Law and the School of Social Work.⁽¹⁾ Both of these disciplines could contribute a great deal to the projected planning committee. It is essential in establishing and operating a forensic clinic that both the legal and therapeutic viewpoints be taken into consideration. To stress one to the exclusion or suppression of the other would without question be the source of innumerable difficulties. Having a social work and law professor on the planning committee would help to insure a modicum of balance in these critical areas.

To supplement the special competences of the law professor, it is suggested that an experienced criminal lawyer should be asked to serve on the committee. Where perhaps a law professor would provide the niceties of viewpoint of the academic, a practicing criminal lawyer could present a more pragmatic point of view, based on the drab and somewhat harsh realities of our present day criminal Courts.⁽²⁾

(1) The naming of these two departments does not imply the exclusion of many other equally feasible possibilities.

(2) One has in mind someone like Mr. Thomas Dohm. The fact that he has been a Magistrate and has practiced criminal law at most levels would attest to the wealth of knowledge he could bring to the work of the committee.

The hypothetical committee at this stage numbers a minimum of eight people. The danger of allowing it to reach unwieldy proportions has already come into view. Nevertheless, it would seem desirable to include representatives from certain other branches of our penal system. As a large number of referrals to the clinic would come from the Probation Service and at least some from prisons, there would be sensible advantage in having representatives from these fields on the committee. The Director of Correction for the Province of British Columbia (or his "alternate") should be there to provide a realistic and detailed account of the problems of institutional administration. By the same token someone from the Probation Branch⁽¹⁾ should have an integral part to play in the planning. The rationale for the inclusion of committee members who are competent to speak the question of the problems and requirements of these two services needs little elaboration.⁽²⁾ All adult offenders who are given a gaol term of less than two years, and all offenders who are placed on probation in British Columbia, other than juveniles in the City of Vancouver, are under the jurisdiction of the Corrections Branch. The Corrections Branch is therefore likely to become one of the principal "consumers" of the clinic's services, and the logic of its advisory role is not difficult to recognize.

(1) Probably this should be the Assistant Chief Probation Officer, Mr. C. D. Davidson.

(2) It is suggested that meetings of the committee should be confidential. Also that its public statements or press releases should be of the type which would not expose any public officials to a charge of conflict of interest.

Reference has already been made to the case and might be put up for the inclusion of some prominent public figure who had no official or professional connections with the field of Corrections. Apart from the "prestige" such a person might be able to lend to the committee (a consideration which some might hold to be trivial or cynical), the kind of figure likely to be a candidate for this office (such as a member of the senior managerial ranks of corporate industry)⁽¹⁾ would in all probability be able to tender the committee expert advice on those problems of financing and administering the proposed clinic which the other members of the committee would be least qualified to deal with--and perhaps most prone to neglect.

* * * * *

It would not appear to be within the scope of this present study to specify the precise means by which the planning committee should be brought into being. Nor can or should it undertake to say how the committee should conduct its business. Nevertheless, it is not difficult to say what kinds of business the committee, in the very nature of the case, would have to deal with. Stated in general terms, these would appear to be:

- (a) Administrative auspices and status
- (b) Organizational structure of the clinic
- (c) Location
- (d) Financing
- (e) Staffing

(1) For example, W. C. Mainwaring, of the Peace River Power Corporation. Mr. Mainwaring has shown an interest in corrections and has been most willing to assist in such projects as fund-raising in the past.

Administrative Auspices and Status

Put simply, this entails a decision as to the apparatus of government the clinic should have and be part of. There are many (perhaps endless) possibilities: establishment as an agency of the Attorney-General's Department; a similar status within the Department of Health or the Department of Social Welfare; development as a part of a large established hospital; and departmental or affiliate status with the University of British Columbia. It is this last alternative which seems to have the greatest net sum of advantages.

In the first place, one of the primary roles of the clinic would be the initiation and prosecution of pure and applied criminological research. The academic climate and the numerous technical resources which would both be available on a university campus would in themselves be capital assets. As a governmental agency, the clinic would almost certainly be subject to pressures to surrender its original function to the task of coping with exigent but routine problems. Its research activities would become desultory and trivial, its clinical services stereotyped, and its teaching fatigued and mediocre.

The status of the clinic within the university setting should be considered at this point. There are a diversity of points to consider in the resolving of this question. The main fact that emerges is that it should not be directly responsible to a designated faculty. The probability of inflexibility and domination would increase greatly under such an arrangement, and is to be avoided at almost all cost.

The clinic would require a high degree of budgetary as well as

operational autonomy. To ensure this autonomy there are at least two or three administrative arrangements which might suffice. One would be to have the clinic affiliated with the university but not under its direct jurisdiction. The staff of the clinic would have the privileges of the university but would not be considered as university employees. Possibly appointment to both the clinic and the university would be the best possible arrangement.

Other suggestions might be to have the clinic set up on the model of the Institute of Industrial Relations. That is, not under any faculty, but directly responsible to the Senate of the University.

Another obvious possibility would be to have it within the Department of Psychiatry at the University of British Columbia. This arrangement could result in budgetary difficulty and is not particularly advocated.

It is not the intent of this study to explore all the administrative possibilities which could be utilized within the university setting. Suffice it to say that the foregoing are a few of the possible choices. There does not appear to be any one plan which has outstanding advantages over the others. The possibilities are numerous and the advantages and disadvantages of each are open to a good deal of argument and controversy.

Although it is our recommendation that the clinic not be part of the faculty of medicine at the university, the clinic should, of course, maintain close liaison with the faculty and make the fullest possible use of the faculty's rich resources of experience,

skill and scholarship. Apart from anything else, it is a brute fact of life that no medical or para-medical faculty will prosper unless it enjoys cordial relations with the organized medical profession. From these two points of view alone, the choice of the university as the "host" institution yields benefits which would be difficult to duplicate through other arrangements.

The clinic would be exposed to less risk of becoming a "political football" if protected by the traditional immunities of the university. If it were under the direct control of a government department, not only would the clinic lack formal autonomy but its independence would be threatened by the belief on the part of the members of the legislature (equally common on the government and the opposition benches) that the actions of public officials are the direct concern of every watchdog M.L.A.

Experience with forensic clinics elsewhere has given evidence that if a clinic is under the control of the judiciary, many serious difficulties are prone to arise. There is a tendency towards inflexibility, and the latent antipathy between the legal and medical profession conjoins with this to produce a high rate of staff turnover. The transcending solidarities of university life might serve to offset these divisive influences.

A further positive feature of university status would be that the clinic's service would not so readily be perceived as the exclusive "property" of one particular level of government, and an unfortunate bias in their patterns of use might thus be avoided. The embattled

relations of the federal, provincial and municipal governments in Canada at the present time do not suggest that a clinic coming under the authority of any of them would be impartially available to the others, or that its staff could easily remain free of embroilment in jurisdictional controversies.

We should not leave this present subject without calling attention to what might emerge as one of the few but important dangers of the clinic's association with the university. We are speaking of that negative side of the university's insulation from public and private caprice which is sometimes described as the "ivory tower" attitude. The principal manifestation of this in the present instance would be the dangers of applying middle-class psychiatric thinking and standards to a problem which demands a pragmatic and rather hard-headed approach. If the clinic follows the practice of many psychiatrists and deals only with verbally fluent, well-motivated and obviously^{ly} treatable patients, it will not be meeting the needs which occasioned its creation in the first place. It is quite clear a great number of referrals from probation officers, social workers and the courts will involve people who lack these characteristics. As often as not, the positively motivated and mildly afflicted client can be handled by the agency concerned anyway. It is for the socially deteriorated, refractory, and attitudinally negative client that social agency personnel generally seek specialized help. If people like these are rejected by the clinic because they lack the will to change and the sophisticated perceptions of the typical middle-class

fee-paying psychiatric patient, the clinic will have opted to give service to no more than a small fraction of the kind of criminal population the courts mainly deal with.

There are powerful reasons for urging that a forensic clinic should be prepared to work with virtually all referrals and with a calculated indifference to conventional prognostic considerations. It is the very absence of any uniformly successful methods of dealing with large classes of deviant personality that argues the need for a clinical faculty with the resources and the determination wanted for the discovery of successful methods. A forensic clinic must be, in some variable degree, selective and discriminating in its intake policies. But the criteria of selectivity should not be those which would naturally be used by a psychiatrist or a social worker concerned with dispensing his scarce resources of time and skill to those most obviously likely to benefit from them. Perhaps the danger we are describing is made no greater by having a clinic attached to a university. But it exists, and it should be avoided.

Organizational Structure of the Clinic

The organization of any institution (and that includes medical and social agencies) should be thought of not as a set of fixed forms which the institution has been given in perpetuity at the moment of its creation, but rather as the embodiment in structural terms of the conditions necessary for the effective accomplishment of its purposes. Organization must therefore be fluid and adaptable, and in a process of continuous accommodation to changes in the institution's purpose

and in the environment with which it has to cope.

It has already been observed that the clinic we propose is likely to have modest beginnings for practical reasons alone, and it may be added that its inherent experimental character provides a further ground for a systematically cautious style of development. As it moves through successive stages of growth, its mode of operation must also change, often in ways that would be unpredictable at an earlier point of development. It is impossible, therefore, to offer any comprehensive recommendations on this subject that would be both detailed and definitive.

It would be senseless, for example, to volunteer specifications for such things as the clinic's service capacity. Its size and scope at any given moment would be a function of the compounded factors of resources and program. It is no more than a truism to say that a high capacity would be desirable if the finances permitted; but the judgment as to whether they did is something which would have to be made, as it were, in situ.

It would be an administrative anomaly for a university department or institute to have a board of directors, but it would be neither without precedent or logic to have a committee of advisors. (A model is available for contemplation, if not necessarily for initiation, in the existing Institute of Industrial Relations.) In addition to the obvious "technical" role that such a committee would be expected to have, it might be a case for assigning it certain policy-making prerogatives. How these prerogatives should

be distributed between the clinic staff and Director, the Administration of the University itself, and the advisory committee, is not a simple question. Possibly it is a problem which can only be dealt with intelligently when experience^h has shown what the clinic's constitutional requirements are going to be.

Similar considerations apply to the composition of the advisory committee. Some of the criteria cited in discussing the selection of the planning committee might be germane here too, and it is obvious that there should be adequate representation of the various professional and academic disciplines involved in the work of the clinic. But beyond this point of specification it would probably be necessary to commit the problem to the good sense and discretion of the people who will have the responsibility for translating the clinic from a well-intentioned proposal into a viable reality.

Location

Our aim here is not so much to settle the question where the clinic should be located as to comment on the respective merits of having it in a rural or urbane centre, within the precincts of an established hospital or in a building by itself, and so forth.

Although there is a long-standing tradition that psychiatric institutions should be difficult to get at, it will seem obvious to those versed in current modes of thought on the subject that the clinic should be in close proximity to the province's main concentration of population. Translated into practical terms this would mean that within Vancouver itself, or at least within very easy

driving distance of Vancouver. Although the administrative link with the university does not require that the clinic make its home on the Point Grey campus, the handiness of that arrangement for ready access to laboratory and library resources should not be overlooked.

Later development might well include the establishment of further clinics in the other population centres of the Province. If similar criteria for location are employed the new clinics could be attached to the province's projected junior and four-year colleges, since these in their turn will almost certainly be established in the main centres of population density (such as Prince George, Victoria, Nanaimo, Kelowna and Nelson). Elsewhere, however, (the population of this Province being as scattered as it is), ad hoc arrangements of one sort or another would have to be devised.

Of course, there would be nothing novel or extraordinary in having a clinic housed in one of the Lower Mainland's large hospitals, even though it were associated administratively with the university. There are medical schools all over the world which attest the feasibility of such an arrangement. If there are advantages in this which clearly outweigh the probable disadvantages (such as the excessively "medical" character it might impart to the clinic's program, and the threat of bureaucratic rigidity) (it should be borne in mind that the university itself will shortly be acquiring a teaching hospital, so that the two birds can be killed with one stone, if that were the aim.

In seeking to choose between these various alternatives, and in dealing with the other problems of planning for and operating the

clinic, it should be remembered that there is a body of experience in such matters which would be foolish to neglect. For example, Dr. John Griffin, of the Canadian Mental Health Association, is known to have been engaged in exploratory work on the subject for some time; and the Provincial Division of the Association (which we have suggested should be represented on the planning committee) would presumably have unimpeded access to the products of that work. Again it has been reported that Dr. Jones, Director of Psychiatric Services for the Victoria General Hospital, Halifax, has made available an account of Nova Scotia's modest experiment with forensic clinics. The creation of a local planning committee is not intended to make it necessary to work everything out from first principles. On the contrary, it is a means by which this can partly be avoided, through the collection and intelligent assessment of other people's experience.

Financing

The new Mental Health Act introduced in the British Columbia Legislature in March 1964 puts the financing of mental health services into a state of some uncertainty.

The central recommendation of the Tyhurst Report was that mental illness should be dealt with in precisely the same organizational, administrative and professional framework as physical illness.⁽¹⁾

Construction costs would be shared by federal and provincial governments and local community ... cost of operating these mental hospitals will be covered by the British Columbia Hospital Insurance Service, presumably with patients paying the standard \$1 a day co-insurance charge.⁽²⁾

(1) March 6, 1964, Vancouver "Sun".

(2) Ibid.

None of this would seem to deal directly with the matter of payment of staff salaries and fees.

The problem is made all the more nebulous by the fact that there are unlikely to be any major changes in the economic basis of Canadian health service before the report of the Hall Commission is brought down some time in mid-1964. Following that, however, there might be many such changes.

The many-sided character of the clinic introduces yet another source of complication. It would be an educational and research centre as well as a mental health facility. The determination of what its main sources of revenue either ought to be or are likely to be could well depend on the "conventional" designation of the clinic as a medical, educational, welfare or penological institution. Presumably its association with the university would constitute some sort of prima facie case for defining its budgetary status in terms appropriate to an institution of higher learning. Unless there are specific contra-indications, however, the clinic should not be regarded by virtue of its educational role as ineligible for financial support from other relevant departments of government.

It is to be expected that in its capacity as a research centre the clinic would be in a favourable position to apply for research grants and awards, both from the foundations and from the appropriate public bodies. Since criminological and psychiatric studies are presently looked upon benignly by those who administer such funds the clinic should experience little difficulty in financing this part of its work.

There is one question concerning the sources of the clinic's funds; but there is another, no less important, concerning the manner in which they are made available. It would be inconvenient, probably embarrassing, possibly intolerable if the clinic were obliged to make all its plans in the arbitrary twelve month sizes. At least some part of the clinic's revenues, especially those reserved for lengthy research projects, should be exempt from the limitations of annual submissions and awards.

In more several terms, the fiscal arrangements devised would have to be of such a kind as to pose no threat to the autonomy of the clinic, once it had been decided what the scope and character of that autonomy should be. Whether it was supported by a mixture of research grants, by provision within the University budget, by a direct grant from the Provincial government, by fees for service provided the courts and other institutions of criminal justice, the clinic would need to have effective jurisdiction in regard to how its main purposes (which we take it for granted the staff and their advisors would be unlikely to challenge) should be interpreted and accomplished. This is not to argue that the clinic should be non-accountable to the public interest on the behalf of which it was created, but to urge that it be protected (in its fiscal status as in other respects) from bureaucratic pettiness and capricious interference.

Staffing

Although the clinic staff might include some people (and rightly

so) who had been "brought in" for the purpose, it should be an explicit aim from the outset to make the fullest possible use of indigenous resources of ability and experience. This could be achieved by ordinary "living" procedures (whether for part-time or full-time positions) through a program of graduate studies, by creating teaching and research fellowships, and by a system of secondment on a short-term basis from existing correctional, psychiatric and educational institutions.

The range of professional and academic disciplines involved could be very great. Psychiatry, law, sociology, psychology and social work would certainly all be represented on the permanent staff, especially insofar as they gave most of their time to the work of diagnosis and treatment. But when we turn to the functions of teaching and research (particularly the latter) it becomes possible to envisage a role for such people as the occasional specialist in public administration, the philosophy of law, or community planning. This is not a fanciful notion, for we have experts in all these fields in Vancouver at the present time. Once again, the arrangements in force at the Institute of Industrial Relations could be invoked as a precedent.

The key appointment would, of course, be that of the Director of the clinic. It should go without saying that it would be absolutely fatal to the clinic's prospects of success if any compromise were made with the requirements of excellence. What is wanted is a forensic psychiatrist with an understanding and hospitable attitude toward

other disciplines, experience in the field in question, and a wholly unequivocal competence in research. Such people are admittedly rare, but to settle for less is to throw good money after bad. If the choice is yielded to considerations of availability, cheapness or innocuousness, then little that is truly useful can be expected to come from the clinic's work.

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Little needs to be said in conclusion. This is not a subject which requires a peroration or admits of formula-like summary. The case for a forensic clinic as an instrument in the rational administration of criminal justice is not these days regarded as a controversial question; and there are no reasons to think the case does not apply to local circumstance. The issue at this point is one of feasibility rather than desirability, and of detail rather than principle. We do not claim to have anticipated or dealt fairly with all such matters of detail, but we have attempted to construct a framework within which the specification of further detail would not be excessively difficult. There comes a point where arguments and recommendations alike must assume conviction and competence in the audience to which they are addressed. That is the point we hope we have reached now.

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