CRIMINALIZATION OF THE MENTALLY ILL:
A Study of Psychiatric Services Within The
Lower Mainland Regional Correctional Centre,
Health Care Centre

By

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A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF SOCIAL WORK

in
THE FACULTY OF GRADUATE STUDIES
SCHOOL OF SOCIAL WORK

We accept this thesis as conforming
to the required standard

THE UNIVERSITY OF BRITISH COLUMBIA
June 1991
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Date January 27, 1991

DE-6 (2/88)
This paper examines the plight of the incarcerated mentally ill. After a consideration of the historical factors which have contributed to the current philosophy and pattern of services throughout North America, and specifically in British Columbia, the paper reports on a qualitative study using participant observation, informal and formal interviews, and Strauss' Constant Comparative Methods which was undertaken to identify the needs of the mentally ill individuals who are serving a term of imprisonment in the Health Care Centre of the Lower Mainland Regional Correctional Centre. Altogether there were eighteen formal participants. They included six mentally ill offenders, six correctional personnel, and six health care professionals. A critical analysis of the major findings - alienation, lack of organizational commitment, and the incongruencies between our social policies and practices - provided the basis for program recommendations. The challenge lies in the building of a vision that values humane treatment for the marginal members of our society.
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When I consider the brief span of my life,  
Swallowed up in the eternity before and behind it,  
The small space that I fill, or even see,  
Engulfed in the infinite immensity of spaces,  
Which I know not, and which know not me,  
I am afraid.  
And wonder to see myself here rather than there,  
For there is no reason why I should be here,  
Rather than there; now,  
Rather than then.  

On beholding the blindness and misery of man,  
On seeing all the universe and man without light,  
Left to himself, as it were,  
Astray to this corner of the universe,  
Knowing not who has set him here,  
What he is here for, or what will become of him,  
Incapable of all knowledge,  
I begin to be afraid.  
As a man who has been carried while asleep  
To a fearful desert island,  
And who will wake not knowing where he is,  
And without any means of quitting the island,  
And thus I marvel that people are not seized  
With despair at such a miserable condition.

Blaise Pascal (1623-1662)
CHAPTER ONE
BACKGROUND TO THE STUDY

INTRODUCTION
To understand our current delivery of mental health services, it is essential that we examine the various historical and contemporary social factors that have influenced the overt manifestation and control of mental illness. This sociological perspective is supported by Mechanic (1983) in his article The Contributions of Sociology to the Understanding of Mental Disorder. He states: "it is difficult to conceive of a mental illness process outside the contours of a particular culture and society" (p.17).

This chapter surveys the historical evolution of the North American mental health system.

HISTORY OF THE NORTH AMERICAN MENTAL HEALTH SYSTEM
In their article Cycles of Reform in the Care of the Chronically Mentally Ill, Morrissey and Goldman (1984) suggest that in the treatment of the mentally ill, there are three separate cycles of reform, with each initiating "a new environmental treatment and new locus of care" (p.785). The authors reviewed the development of the mental health service delivery system, and coined the term "a cyclical pattern of institutional reforms" (p.785). The pattern of institutional
reforms can be summarized in three stages as follows:

1) moral treatment and the asylum;
2) the mental hygiene movement and the psychopathic hospital; and
3) the community mental health movement and the community mental health centres.

**MORAL TREATMENT AND THE ASYLUM**

Prior to the 19th Century, the mentally ill individual was not ostracized from the community. The lunatics or the insane were generally treated no differently than the other groups of social deviants such as the morally disreputable, the indigent, the vagrants, the criminals, the possessed, and the physically handicapped. Individuals who deviated from the social norm were either the responsibility of their families or were left to their own devices, languishing in the countryside. Only the behaviourally violent individuals were confined in jails.

The early 19th Century gave rise to a "broad-based social reform movement aimed at bettering the conditions of the less fortunate members of society" (Morrissey and Goldman, 1984, p.786). This sentiment was highly influenced by the works of two Europeans and one American - Phillippe Pinel in France, William Tuke in England, and Dorothea Dix in the United States. These three individuals were the early reformers in the institutional management of the mentally ill. While Pinel
ordered the release of chains and the abolishment of barbaric treatment, Tuke revolutionized the institutional environment, and advocated for the development of asylums. Dix was responsible for revealing the shocking conditions endured by the confined mentally ill to the State Legislature of Massachusetts. Her efforts resulted in the construction of specialized facilities for mentally ill individuals. As Morrissey and Goldman (1984) state:

"The 'moral treatment'...[Pinel, Tuke, and Dix]...championed contributed to the growing acceptance of a medical-psychological rather than a theological model of mental illness and led to the establishment of asylums for its treatments" (p. 786).

The belief of moral treatment was essentially the belief that "insanity could be cured by segregating the 'distracted' into small, pastoral asylums" (Morrissey & Goldman, 1984, p. 786). Asylums were defined as small public institutions where 'patients' would receive humane care and gain skills in an atmosphere of kindness. However, with the rise of urban population and rapid industrialization, the number of patients in need of care increased dramatically. Asylums became overcrowded and understaffed. The transformation from "small therapeutic asylums to large, custodial institutions" (Ibid) lent support to the increased use of physical control, and the concept of individualized moral treatment was lost. Mentally ill individuals were confined in remote areas, and were soon neglected, isolated, and abandoned. Treatment was synonymous with warehousing. As Morrissey & Goldman (1984) point out:
"By the 1870s...the function of state asylums had been clearly delineated. The central purpose was defined by state legislatures in terms of custodial care and community protection; treatment was of secondary importance. Emphasis was placed on the custody of the largest number of patients at the lowest possible cost. The small pastoral retreat that offered hope and humane care had been transformed in a general-purpose solution to the welfare burdens of a society undergoing rapid industrialization" (p.786).

THE MENTAL HYGIENE MOVEMENT AND PSYCHOPATHIC HOSPITALS

The demise of the moral treatment movement eventually gave rise to the second cycle of institutional reform, the mental hygiene movement. This movement was highly influenced by three European psychiatrists, namely Emil Kraepelin, Eugene Bleuler, and Sigmund Freud. The works of these individuals generated a great deal of optimism within the psychiatric profession. In order to be recognized as part of the mainstream medical profession, psychiatrists as a group, began to seek for professional legitimacy by devoting their efforts to scientific research. In his article Historical Origins of Deinstitutionalization, Grob (1983) points out that emphasis was placed on the empirical study of the etiology, pathology, diagnosis, and treatment of mental disorders. And as such, the choice between the 'curing of disease' or the 'caring for the mentally ill' was no longer a professional dilemma. "The concern with new techniques reflected a commitment to medical science and disease rather than to patient care" (Grob, 1983, p.26).
In his autobiography, *A Mind That Found Itself*, Clifford Beers (1908) aroused a tremendous amount of public sympathy regarding the abysmal treatment of the mentally ill. Subsequently, Beers successfully gained the support of various professionals and formed the National Committee for Mental Hygiene. According to Morrissey and Goldman (1984),

"This reform organization revived the notion of the treatability of mental disorder, especially by early intervention with acute cases. Mental Hygienists advocated creating a 'psychopathic hospital', an acute treatment or reception facility affiliated with university training and research institutes" (p.787).

Although off to a good start, it wasn't long before it became evident that these 'psychopathic hospitals' were providing care for a heterogenous group - the aged, the physically disabled, and individuals whose undesirable behaviors were directly linked to somatic disorders (Grob, 1983). A case in point is Grob's reference to the decline of local almshouses for the elderly in the U.S.:

"The decline, however, was more apparent than real, for the number of aged mentally ill persons committed to mental hospitals was rising steadily. What occurred, in effect, was not a deinstitutionalization movement, but rather a transfer of individuals between different types of institutions. The shift was less a function of medical or humanitarian concerns than a consequence of financial considerations... local public officials seized upon the fiscal advantages inherent in redefining senility in psychiatric terms...[as]...the burden of support would be transferred to the state" (Grob, 1983, p.17). (my emphasis)
Again, psychopathic hospitals became overcrowded and understaffed. The goals of the mental hygiene movement fell by the wayside in the absence of government financial support. In-patient facilities became undesirable places of employment for psychiatrists primarily because they were perceived to be outmoded and passe. Psychiatrists who were employed in hospitals received less financial remuneration than their counterparts who were employed in community mental health centres. Therefore, many sought to practice at out-patient clinics. Many of the psychiatrists who stayed behind in the psychopathic hospitals devoted their time and interests into the development of various somatic treatment techniques; such as, insulin therapy, electroconvulsive therapy, and psychosurgery, but not patient care. (Grob, 1983)

COMMUNITY MENTAL HEALTH MOVEMENT

The advances in psychopharmacology during the 1950s lent a certain optimism to the treatment of the mentally ill. The introduction of Chlorpromazine, an antipsychotic drug, promised to alter the future of Psychiatry. Not only did this change minimize the use of intrusive somatic treatment techniques but also, a shorter institutional stay for psychiatric patients became a viable alternative. Studies by Barton (1959) and Goffman (1961) identifying the debilitating effects of institutionalization provided additional ammunition to revolutionize public and professional attitudes towards the
mentally ill. The Civil Rights Movement also served as a major impetus. As Bachrach (1983) notes:

"the movement emphasized the inalienable rights of the mentally ill and their legitimate claim on society.... Deinstitutionalization sought to exchange physically isolated treatment settings for services to be provided in the patients' home communities on the assumption that community based treatment is more humane and therapeutic. Since the physical isolation of patients was understood to be inevitably accompanied by an insidious social exclusion that had to be corrected, those who pioneered in deinstitutionalization objected to both the content and quality of care in large, often secluded, mental hospitals" (p.7).

Prompted by the foregoing factors, Robert Felix (1961), director of the American National Institute of Mental Health, put forth the first major proposal for the Community Mental Health Movement. In 1963, President Kennedy made the first and only presidential address on mental illness. He stated that psychiatric institutions were:

"understaffed, overcrowded, so unpleasant that it makes death the only hope of release....Central to a new mental health is community care, and pouring funds into outmoded institutional care should be replaced because it makes little difference to the mentally ill" (cf. Group for Advancement of Psychiatry, 1978, p.302).

Hence, the emergence of the third cycle of institutional reform in the United States - the community mental health movement - was formally endorsed by the Community Mental Health
Centre Act in 1963. Community psychiatry, and the social policy of deinstitutionalization were the result of several factors: the abandonment of psychiatric hospitals by the psychiatric profession; the advent of psychotropic medication; changing public attitudes towards the mentally ill; the Civil Rights Movement; and finally, the anticipated economic savings. After all, "If community based care was better (both more therapeutic and humane) and cheaper (less costly) how could its superiority be denied?" (Bachrach, 1983, p.7).

In their 1985 article *The Alchemy of Mental Health Policy: Homelessness and the Fourth Cycle of Reform*, Goldman and Morrissey identified one of the key deficits of the Community Mental Health Centre Act of 1963. That is, it did not provide specific mandates for the mental health centres to "coordinate their efforts with state mental hospitals or to care for chronic patients" (p.728).

"As a result, mental health centres primarily served new populations in need of acute services and failed to meet the needs of acute and chronic patients discharged in ever increasing number from public hospitals. Furthermore, centres were not required to provide for housing or income support for discharged mental patients. Homelessness and indigency were predictable outcomes for many" (Ibid).

Leona Bachrach (1978) adds:

"Perhaps the most serious single issue is the fact that the deinstitutionalization movement, which was originally designed to provide the chronically mentally ill relief from the inhumane conditions of
institutions, has let these patients 'fall through the cracks'. These patients—the very ones who have been dehumanized through oversight and denial in past—have somehow, in the process of reducing state hospital populations, largely been lost to the service delivery system" (p.575).

The question of how we can account for the vast difference between our ideals of the 1950s and the current realities has been discussed at length in the literature. The reality remains that our mentally ill population within the community is socially isolated, economically impoverished, pervasively exploited, vocationally disadvantaged, emotionally disengaged, and repeatedly rejected; a far cry from being a part of the mainstream society. Certainly, the literature during the past five years strongly supports Gralnick (1983)'s comment: "mental illness has always presented an enormous problem to society. Deinstitutionalization has aggravated rather than lessened it" (p.12).

THE COMMUNITY MENTAL HEALTH MOVEMENT IN CANADA

In their review of the history of mental health 'depopulation' in Canada, Herman and Smith (1989) assert that "What is certain is that mental hospitals massively declined in population" (p.386). Furthermore, this population "continues to decline" (Ibid).

Although the impact of the community mental health movement has been less extensively documented in Canada than the United
States, what is documented shows remarkable similarities. For example, Allodi and Kedward (1973) concluded that in the absence of a comprehensive support system, "former mental hospital patients will return to pre-nineteenth-century conditions, and become a social outcast [sic], with no definite identity or specialized services" (p. 289).

Kedward, Eastwood, Allodi, and Duckworth of Toronto published an article in 1974 titled The Evaluation of Chronic Psychiatric Care, and in it, the authors state:

"While nobody would wish to return to the unhappy conditions of indifference and apathy found in asylums in the past, a rigorous examination of recent mental health statistics does not necessarily justify the assumption that the modern mental hospital is wholly redundant or anachronistic....If, in addition, as some authors suggest, large numbers of patients discharged from mental hospitals have joined the ranks of the homeless and the prison population, the radical changes in management of severe psychiatric syndromes in western countries during the last decade or more may prove to have had a less satisfactory impact upon patient status than is commonly supposed" (pp.522-523).

Similarly, Herman and Smith (1989) made the following commentary:

"But in Canada like the United States, there was no absence of problems. Few mourned the shrinkage or loss of mental hospitals, but soon, there were complaints of patients being 'dumped' into the community with some ending up in nursing homes, gaols, or ghettos. The issues of homelessness and chronic illness, though less prominent than
in the United States, were similarly decried by many social planning agencies and interested groups.... In Canada, as a whole, the availability of universal medical care has favourably influenced its distribution. [sic]...However, removal of the financial barriers does not guarantee that those more in need of care actually receive it. The chronically mentally ill are not the most popular patients, and the quality of care available to them varies from province to province" (p.387).

Finally, perhaps what is most troubling for social policy makers, is the realization that community care is simply not cheaper than institutional care (Herman and Smith, 1989).

THE COMMUNITY MENTAL HEALTH MOVEMENT IN BRITISH COLUMBIA

The year 1957 marked the beginning of the community mental health movement within the province of British Columbia. It was the year when the first community mental health clinic was established.

In 1959, the B.C. government consulted with the American Psychiatric Association regarding the future directions of the provincial mental health system. The recommendation was clear - mental health services should be regionalized.²

Regionalization of services included provincial travelling clinics, in-patient psychiatric emergency services within local hospitals, aftercare for discharged psychiatric patients, boarding home programs, regional mental health clinics, and a
new Mental Health Act. All of these were designed to complement the goals of the Deinstitutionalization philosophy and policy. In their 1967-68 annual report, the Mental Health Branch of the Ministry of Health redefined its role from a service provider to the facilitator of reorganization of the provincial mental health programs.

In 1976, Dr. John Cumming and his colleagues published Community Care Services in Vancouver: Initial Planning and Implementation, an article that has had major influence on the development of mental health services within British Columbia. The authors made the following observation:

"The burden on Vancouver General Emergency resulted in low morale and little therapeutic work, most staff time being invested in finding hostels or other places in which to dispose of patients. Worse still were the large numbers of patients who found access to treatment only through the police, jail or courts where they were either certified or remanded to the mental hospital" (p.20). (my emphasis)

In 1979, Dr. John Cumming was requested by the provincial government to assess the existing mental health services and make some recommendations for future action. In this Report of the Mental Health Planning Survey, also known as the Cumming's Report, perhaps the only non-critical comment made regarding the provincial psychiatric hospital was: "While many settings were depressing, none were [sic] shocking" (p.57). What Cumming found most troubling was that "In practice many eligible
patients are refused admission or placed on a waiting list....the number of patients that are admitted become a direct function of considerations other than where the patient resides or what level of care he needs" (p.55). This is supported by the findings within the community care teams. For example, "Almost all team members mentioned difficulty in getting hospital care during periods of relapse" (p.17). With respect to the discharged psychiatric patients, "Team members believe some patients are being exploited and ill-treated and feel able to do little about it" (p.25). Generic critiques such as 'fragmentation', 'lack of cohesion', 'lack of coordination', and 'duplication of services' found commonly in the American literature also found their way into this report.

During this same time period, the City of Vancouver conducted a study on the Hard to House Psychiatric Clients. What became evident was that our local experience was remarkably similar to the American experience. That is:

"A small percentage of 'difficult' cases in the community are utilizing a disproportionately large percentage of available services on a continuing basis without satisfactory improvement in their life condition" (p.6).

In his article The Homeless Mentally Ill: A Report from Vancouver, Simon Davis (1987) made the following observation:

"Overall, the survey revealed that, for many of the mentally ill, life in the inner city meant a tenuous, unstable, socially impoverished sort of existence, with people
struggling - often unsuccessfully - to maintain interpersonal relationships and a sense of independence" (p.12).

**SUMMARY**

In their analysis of the three 'cycles of institutional reforms' - the moral treatment and asylums; the mental hygiene movement and psychopathic hospitals; and the community mental health movement and community mental health clinics - Goldman and Morrissey (1985) made the following comment:

"Each of these reforms promised that early treatment of acute cases would prevent chronic mental illness. Each innovation proved successful with acute and milder - not chronic - forms of mental disorder yet failed to eliminate chronicity or to fundamentally alter the care of the severely mentally ill. In each cycle, the optimism of reform gave way to pessimism and therapeutic nihilism towards increasing numbers of incurable chronic mental patients. In the face of an expanding population of needy patients, public support turned to neglect" (p.727).

Moreover,

"The zeal of community mental health activists for trying to solve social problems without also focussing on the need for humane care of the chronically mentally ill, in part...contributed to the new set of social problems associated with deinstitutionalization" (p.728).

In summary then, as Brad Pearce (1990) states:

"The United States began and progressed with deinstitutionalization at a much faster pace than Canada, hence many of the unanticipated problems and consequences of deinstitutionalization, such as homelessness, criminalization, community resistance and poverty, were first evident there. These
problems are now clearly evident in Canada as we 'catch up' to the United States" (p.2). (my emphasis)

THE CRIMINALIZATION OF THE MENTALLY ILL

Review of professional journals, academic literature, and popular press indicates a plethora of criticisms regarding the problems generated from the Community Mental Health Movement. In his article Care of the Chronically Mentally Ill - A National Disgrace, Robert Reich (1973) maintains that:

"Freedom to be sick, helpless, and isolated is not freedom....Our present policy of discharging helpless human beings to a hostile community is immoral and inhumane. It is a return to the Middle Ages, when the mentally ill roamed the streets and little boys threw rocks at them" (p.912).

Similarly, Dumont (1982) concludes that deinstitutionalization is:

"nothing more or less than a polite term for the cutting of mental health budgets. Under a patina of community mental health rhetoric we are returning to the pre-Dorothea Dix situation" (p.367).

Although Reich was describing the experience of New York State, similar sentiments have been expressed by various individuals all across North America. Within Canada, Lightman (1986) for example, suggests that "Deinstitutionalization, not as a concept but rather as a practice, must rank as one of the greatest frauds of our day" (p.26). Although it is agreed that treatment of the mentally ill is the raison d'etre of
the Community Mental Health Movement, many argue that it has "become increasingly apparent that society has chosen the easy and cheap way out" (Zusman and Lamb, 1977, p. 887). One of the easiest and cheapest ways out is the criminalization of the mentally ill.

Perhaps one of the most frequently cited American articles in this area is that of Marc Abramson's (1972) The Criminalization of Mentally Disordered Behavior: Possible Side-Effect of a New Mental Health Law. In this article, Abramson argues as follows:

"If the entry of persons exhibiting mentally disordered behavior into the mental health system of social control is impeded, community pressure will force them into the criminal justice system of social control. Further, if the mental health system is forced to release mentally disordered persons into the community prematurely, there will be an increase in pressure for use of the criminal justice system to reinstitutionalize them....From my own vantage point as a psychiatric consultant...mentally disordered persons are being increasingly subjected to arrest and criminal prosecution....Police seem to be aware of the more stringent criteria under which mental health professionals are now accepting responsibility for involuntary detention and treatment, and thus regard arrest and booking into jail as a more reliable way of securing involuntary detention of mentally disordered persons. Once the criminal justice machinery is invoked, it is frequently hard to stop" (p.15).(my emphasis)

Within Canada, and specifically Toronto, Allodi et al (1977)'s research findings support the "hypothesis that the
reduction of hospital beds has been associated with an increment in the number of psychiatric patients in jail" (p.3) between 1969 and 1973. Similarly, Borzecki and Wormith (1985) from Ottawa conclude that:

"There is a limit to society's ability to absorb the large numbers of people discharged....Therefore, when people with psychiatric illnesses show symptomatic bizarre behavior, the public tends to invoke the criminal justice system to remove them from the community...changes in civil commitment proceedings and more limited psychiatric placements have placed bureaucratic obstacles in the way of emergency admissions. Therefore, arrest becomes a much less cumbersome method to remove the disruptive psychiatrically ill person. The police cannot be faulted on such a practice....If the 'forfeited' patients continue to be socially disruptive and continue to be excluded from psychiatric facilities, they will be readily accepted by the criminal justice system. In effect, it has become the system 'that can't say no'" (pp.242-3).

Furthermore, in the article Criminalization of the Mentally Ill: Part I, the authors Holley and Arboleda-Florez (1988) from Calgary, asserted that although:

"the prevalence of psychiatric illness among criminal populations in Canada has been poorly documented, available data indicate that as much as 65 percent of provincially jailed offenders may be mentally ill. Evidence from other countries shows a range of between 10 and 50 percent (pp.81-82).

Within our own local system, Stephen Hart and James Hemphill (1989) conducted the first research study to determine
the prevalence of and service utilization by Mentally Disordered Offenders (MDOs) at the Vancouver Pretrial Services Centre (VPSC). As part of this study, Hart and Hemphill assessed 576 admissions, (459 different inmates) over a period of three months. Assessment was based on a series of psychometric tests as well as review of each individual's medical and social history. Hart and Hemphill concluded that:

"The prevalence rate of MDOs among admissions observed in the survey--23.8%--was high in an absolute sense. Because of the methodological strengths of the survey, however, we are confident that this figure is an accurate one. As well, it is well within the range reported by other researchers" (p.45).

With respect to the future of the Vancouver Pretrial Services Centre, Hart and Hemphill suggest that:

"there are two factors that may foreshadow a rise in the prevalence of MDOs. First, the trend towards deinstitutionalization is continuing. Should the provincial government follow through on its stated plans to trim the population at Riverview, VPSC can expect to receive a significant number of those patients discharged into the Greater Vancouver area....A second relevant factor is the imminent closure of the Lower Mainland Regional Correctional Centre (LMRCC). At present, because it has a relatively large health care centre, LMRCC houses a number of inmates (both remanded and sentenced inmates) with serious mental disorders. If the facilities currently under construction to replace LMRCC have fewer hospital and segregation beds available for MDOs, VPSC can probably expect to receive some of the 'excess' MDOs" (p.46).
COST VERSES CARE: THE DILEMMA

In their article, Borzecki and Wormith (1985) raised the question of

"why a public alarm should be raised over the situation since the criminalization phenomenon may simply reflect changes in the relative use of two methods for dealing with the socially aberrant. It is obvious from a simple actuarial, financial model that society finances both systems, and it may be less expensive to detain persons in jail" (p.246).

Although Belcher (1988) was not responding directly to their question, he does argue that "Responsibility for these individuals needs to remain in the mental health system and not be displaced to a criminal justice system that is not designed to appropriately care for the mental health needs of these individuals" (p.194). Furthermore, "to the extent that society ethically subscribes to a rehabilitative model, the mentally ill should be put in facilities which specialize in their treatment and care" (Borzecki and Wormith, 1985, p.246). (my emphasis)

In his plea for a broad public participation in the choice of mental health services in Canada, Lightman (1986) argues quite convincingly that:

"all social and economic policy in any society is built upon fundamental value choices. The frequently-cited argument of economic necessity - that we have no choice but to cut back government spending in the social and health areas in order to conquer
inflation and to concomitantly reduce the deficit - is fallacious. It is not a statement of any objective fact or reality, but rather reflects a particular constellation of presumed social priorities. The message for professionals and others concerned to protect our social and health systems is that future debate must address fundamental questions of values and not become bogged down in econometric technologies" (p.25).
CHAPTER TWO
SYSTEMS OF CARE FOR THE MENTALLY ILL
IN THE PROVINCE OF BRITISH COLUMBIA

INTRODUCTION
This chapter will begin by briefly describing the two provincial psychiatric institutions within the Lower Mainland designed to accommodate the chronically mentally ill population. It will then move on to the one provincial correctional institution that, either by default or by design, finds itself housing a group of mentally ill individuals.

RIVERVIEW MENTAL HOSPITAL
In 1964, the British Columbia Provincial Mental Hospital amalgamated with Crease Clinic, a short stay psychiatric unit, and formed what is now the principal in-patient psychiatric facility of the province, Riverview Hospital. During this time period, a series of community facilities began to emerge. Of importance is the development of in-patient psychiatric units within the local general hospitals. Examples are the Psychiatric Assessment Unit of Vancouver General Hospital, the Eric Martin Pavilion of Royal Jubilee Hospital in Victoria, the Maples Adolescent Treatment Centre in Burnaby, and the Health Sciences Complex at the University of British Columbia. Implicit in this decentralization movement was the intent that the local hospitals would offer short-term treatment for
acutely mentally ill patients, and refer chronically mentally ill patients to Riverview Hospital for long-term treatment. However, as the Cumming's Report (1979) indicated: "Difficulty in arranging admissions of patients to Riverview is almost universally complained of by staff members of services throughout the province" (p.56).

What became evident was that despite the development of various psychiatric units in local hospitals, the needs of the chronic mentally ill remained unmet. Under the auspices of the community mental health movement and consistent with the deinstitutionalization policy, patients were discouraged from seeking admission to any psychiatric facility. The B.C. Mental Health Act (1964) required and still requires that, except for emergencies, the individual must be seen by two medical practitioners. Only if it is agreed between the two physicians that the individual is of 'unsound mind' and a 'danger' to self or others, can the individual be admitted to a psychiatric facility. The irony of this is that many mentally ill individuals are denied admission to local psychiatric units simply because they may present a 'danger' to self and/or to others. They are frequently turned away from the hospital because the facility itself is not equipped to accommodate their psychopathology. Often, the acute local hospitals do not have sufficient staff resources to ensure security nor do they have the appropriate room to contain the patient's acting-out
behaviors. It would seem logical then, that these 'dangerous' patients should be transferred to Riverview Hospital. After all, Riverview was designed

"for the benefit of 'patients who do not fit'--the most severely and chronically ill, for whom adequate assessment and treatment is not possible within the acute hospital or in community outpatient settings. This capacity is required for cases where the individual or the community must be protected and also when the mental illness is so severe that patients require structure and good nursing care, not to mention the safety and security of an asylum-like environment" (Mental Health Consultation Report, Ministry of Health, Province of B.C., 1987, p.13).

However, the reality is that Riverview is at present undergoing a major deinstitutionalization process itself. As stated at a local conference sponsored by Riverview Hospital (November 1989), while the in-patient population of Riverview was approximately 5,500 in 1950, in 1989 its total was approximately 800.

While it is commendable that Riverview Hospital is able to cultivate a respectable number of resources for its patients for community placements, the key issue here is the strict admission criteria. That is, many individuals who meet the statutory guidelines of the Mental Health Act are denied admission because, amongst other reasons, there is an informal agreement to refuse patients who may have had involvement with the criminal justice system or are currently before the court.
It is assumed that these patients are too 'violent', 'difficult', or 'dangerous' for their facility, and that they are the responsibility of either the Forensic Psychiatric Services or the criminal justice system.

**FORENSIC PSYCHIATRIC SERVICES**

The British Columbia Forensic Psychiatric Commission was established in 1974. Its primary mandate, under the B.C. Forensic Psychiatric Services Act, is to provide psychiatric assessments for the courts and to provide treatment for individuals who are held at the direction of the Lieutenant Governor. In addition, the Forensic Psychiatric Outpatient Services provide community follow-up care for individuals who are required by their probation orders to receive psychiatric treatment.

The Forensic Psychiatric Institute is an in-patient psychiatric facility located at Port Coquitlam designed for those individuals who meet one or more of the following criteria:

1) remanded by court for psychiatric assessment;
2) found 'Unfit to Stand Trial';
3) found 'Not Guilty by Reason of Insanity';
4) serving a provincial jail sentence (two years less a day) and are certified under the B.C. Mental Health Act.

A brief discussion of these four groups is warranted.
The primary mandate of the Forensic Psychiatric Commission is to provide court ordered pre-trial psychiatric assessments. This mandate is based on the long held view that individuals who are before the court should be able to fully comprehend and appreciate the nature of a trial. The court requires assurance that an individual is able to participate in his or her own defence. A common misconception is that an individual who is remanded for psychiatric assessment is also receiving treatment. This is not necessarily the case as the primary goal is to determine if the individual is 'Fit to Stand Trial'. An individual who is found 'Unfit to Stand Trial', a legal rather than a psychiatric term, must be returned to the Forensic Psychiatric Institute for treatment until he or she is found 'Fit'. Individuals who are severely mentally ill or of limited intelligence may never become 'Fit'. It should also be noted here that an individual can be certified as mentally disordered under the Mental Health Act and concurrently be deemed 'Fit to Stand Trial'.

Once the individual is found 'Fit' to stand trial, the court may wish to address the mental state of the individual at the time of the offence. Insanity is not a defence of preference as individuals who are found 'Not Guilty By Reason of Insanity' have to be returned to the Forensic Psychiatric Institute and, under the Warrant of Committal, remain at the pleasure of the Lieutenant Governor indeterminately until the order is rescinded.
The last group comprised of individuals who have been certified under the Mental Health Act while serving a provincial prison sentence. This group is of low priority for admission to the Forensic Psychiatric Institute. Depending on the demand for bed spaces, some of these individuals are returned to their host institution immediately following initial signs of stabilization. To be fair, since these individuals are placed at the Forensic Psychiatric Institute on a Temporary Absence Status from their host correctional institution, they have to be confined in the maximum security area. As a result, they do not have the benefit of the rehabilitation programs and only receive psychopharmacological treatment.

During the past two years, a protocol has been established between the Forensic Psychiatric Outpatient and Inpatient Services, where an outpatient client can be admitted to the Forensic Psychiatric Institute when certified under the Mental Health Act. Naturally, this is also dependent on the availability of bed spaces. Perhaps what is important with this protocol is that it is a broadening of admission criteria to the Forensic Psychiatric Institute, in direct response to the strict admission criteria of other psychiatric facilities.

Within the Forensic Psychiatric Institute, there is also a group of patients who are of civil 'Involuntary' status. In
simple terms, this is a group of individuals kept at the facility not because of the legal requirements of the criminal law, but only under the civil provisions of the Mental Health Act. Individuals in this group are generally severely and chronically mentally ill, respond poorly to traditional psychopharmacological treatment, and require a long period of in-patient treatment. The alleged offences that brought them into the Forensic system originally have been 'stayed' by the Crown Counsel office which has agreed that these individuals require and would benefit from treatment for an extended period of time rather than being processed through the criminal justice system. Although this group should be transferred to Riverview Hospital, typically Riverview Hospital because of its strict admission criteria, does not accept them. As a result, this group remains at the Forensic Psychiatric Institute, in some cases for years, awaiting a transfer to Riverview Hospital. Indeed, there are occasions when the patient is not placed on the transfer list for fear that he or she will be discharged prematurely under the deinstitutionalization policy.

What we have seen then, in the past two years, is the expansion or the increased flexibility of admission criteria within the Forensic Psychiatric Institute in response to the demands that have emerged from the deinstitutionalization movement. While this facility was designed for the maximum capacity of 121 patients, it has been operating recently at a relatively stable capacity of 145 patients.
The primary problem, as I see it, is that regardless of what the legal status may be, professionals and public alike, continue to feel ambivalent towards mentally ill individuals who have been involved with the Forensic Psychiatric system. While they may sympathize with their experience and circumstances, they are also reluctant to work with or accept them in the same manner. This group's history with Forensic Psychiatric Services will always weigh heavily against them. It is often used to rationalize failure to provide them with much needed services.

LOWER MAINLAND REGIONAL CORRECTIONAL CENTRE

The Lower Mainland Regional Correctional Centre (LMRCC), also known as Oakalla, was established in 1914, and for many years it was the only provincial maximum security correctional institution in British Columbia. Its maximum capacity was twelve hundred inmates per day during the 1950's. The average number of inmates it houses currently (1990), is between four to five hundred on a given day. Within the institution, inmate behaviors are guided by the Correctional Centre Rules and Regulations of the Corrections Act.

The Health Care Centre of Lower Mainland Regional Correctional Centre is now a distinct and separate building located within the confines of the correctional grounds. Its maximum capacity is approximately 65, although it seldom houses
that many as there are not enough beds available. The Health Care Centre is composed of six wards and two independent rooms. Wards one and two, which are located on the main floor, are designed for the inmates who have physical illness; e.g. broken leg, heart problem, etc. Wards five and six, located on the second floor with the other wards, are primarily for inmates who are mentally ill. Wards three and four contain inmates who are psychiatrically vulnerable, but are generally higher functioning than inmates in wards five and six either because their illnesses are less severe or because their illnesses are in remission. This group appears to engage in fewer acting-out behaviors.

Health care is provided by a constellation of health care professionals, most of whom are employed on a part-time sessional/contract basis. They include: two medical doctors, one psychiatrist, three psychologists, two full-time pharmacists, one physiotherapist, one dentist, one dermatologist, one optometrist, one dental hygienist, and one orthopaedic specialist. Up until August 1989, there was twenty-four hour regular nursing staff coverage. This has now been cut back to only seven a.m. to eleven p.m. coverage. Inmates who require surgery or laboratory tests are transferred to the local acute hospitals, and are often returned to the Health Care Centre for follow-up care. As well, there are on-call psychiatrists available in the evenings and weekends for psychiatric emergencies.
Health care professionals provide services to all the inmates from the whole institution. Not all inmates are seen at the Health Care Centre, however. Many are seen by either a medical doctor and/or nurse during their daily 'sick parades'. Discretion is left to the inmates to submit a request, and the correctional staff to inform the health care professionals of the request to be seen. When the health care professional finds it appropriate, he or she will request that the inmate be transferred to the Health Care Centre for closer monitoring.

Upon admission, each inmate is 'screened' by a classification officer. Screening consists of reviewing the inmate's history of offences, past institutional behaviors, court recommendations, medical history, and conducting a direct interview with the inmate. It should be noted here that information may not be available at the time of the admission. Inmates who require protective custody due to the nature of their offence, or who are perceived to be hostile, threatening, and/or dangerous—that is, a security concern—are often isolated in the Westgate B cell block. Inmates who are a security and suicide risk may be placed in South Wing for close observation. Inmates from Westgate B and South Wing Observation usually receive health care in their cells rather than being transferred to the Health Care Centre.
Inmates who have a known psychiatric history are often sent directly to the Health Care Centre, particularly if they exhibit signs of unusual or bizarre behaviors at the time of their admission. Naturally, this is dependent on the availability of space as well as the security clearance as identified earlier. Inmates who do not exhibit unusual or bizarre behaviors at the time of their admission may be placed in with the general population until there are indications of mentally disturbed behavior.

Inmates who become acutely psychotic, and present a danger to self and/or others may be certified under the B.C. Mental Health Act by two physicians. In these circumstances the inmate could either voluntarily accept psychopharmacological treatment at the Health Care Centre and/or be transferred to the Forensic Psychiatric Institute via a Temporary Absence application. Involuntary treatment can not be imposed since the Health Care Centre of Lower Mainland Regional Correctional Centre is not a designated psychiatric facility. As mentioned earlier, Riverview Hospital will not accept individuals who are serving a sentence in a correctional institution. Transfer to Forensic Psychiatric Institute is dependent on the availability of bed space. On some occasions, inmates are released into the community before they can be transferred.
Each inmate of the Health Care Centre is assigned a correctional staff member who is responsible for the inmate's care management. The actual substance of the case management is highly dependent on the inmate and the assigned correctional staff member. The primary focus is placed on helping the inmate adapt to his period of incarceration rather than any other kind of planning.

At the recommendation of the correctional staff member/case manager, inmates can be eligible for the 'work program'. This program basically entails janitorial duties, meals preparation, laundry services, and yard maintenance. Inmates receive a small sum of money in return for their work, as well as a greater degree of freedom and time to spend in the games room. Within the Health Care Centre, inmates from Wards one and two (i.e. inmates with physical illnesses only) are usually considered first for the work program. Similarly, inmates from Wards three and four are more eligible for the work program than the inmates from Wards five and six, as the former group is perceived to be more stable and higher in their level of functioning.

There is a woodworking area in the basement of the Health Care Centre. At one time this was utilized as a rehabilitative workshop for the mentally ill inmates under the supervision of an Occupational Therapist. During the past year, this area has
not been used at all, primarily due to staffing shortage and fiscal constraints. Finally, there are regular Alcoholics Anonymous and Spiritual Guidance meetings available for all inmates who choose to attend, subject to security management of course.

When the prison sentence imposed by the court has expired, the correctional system must release the inmate. In these circumstances, the released psychiatrically impaired inmate could remain in the treadmill of a kind of 'greyhound therapy'. That is, bouncing back and forth, almost like a 'ping pong ball' between the community, the mental health system, and the criminal justice system.

ENTRY TO THE SYSTEM

Our mental health system enables an individual to voluntarily admit him or herself into a psychiatric facility for a duration of hospitalization as deemed necessary. It also permits a concerned family member or friend to escort the psychiatrically impaired individual to a hospital and seek admission for psychiatric intervention. However, there is a group of mentally ill individuals in our community who do not have the benefit of or enjoy close familial and interpersonal ties. The reasons for this 'disconnectedness' are manifold and complex and they will not be addressed in this section. Suffice to say that this group of 'disconnected' psychiatrically
impaired individuals is often unable or unwilling to reach out for the necessary help in a socially acceptable manner. As a result, individuals in this 'disconnected' group who behave in a socially inappropriate manner are more likely to be brought to the attention of law enforcement officials than mental health professionals. Individuals in this group find themselves caught between the mental health system, the community, and the criminal justice system.

In British Columbia, a police officer has the discretionary power either to take the apprehended individual to a psychiatric facility or, alternatively, to lay criminal charges and place the individual in jail pending his or her being processed through the criminal justice system. From my own experience, I have found that the latter is dependent on the nature of the offence and the feasibility of admission into a psychiatric facility. When all the psychiatric facilities are on "diversion"--that is, when there are no psychiatric beds available or, when the individual is deemed unsuitable for the facility because he or she is not certifiable under the Mental Health Act or is too potentially aggressive--the police official is left with little choice but to lay criminal charges and to remove the individual from the community to the local jail.
While the individual is in the local jail, he or she may be seen by a medical doctor if such was the recommendation of the police official. From the results of the Mental Status Examination and the review of the available information, the medical doctor will make recommendations based on the clinical findings. The primary focus is on the individual's 'Fitness to Stand Trial'. 'Fitness to Stand Trial' is a legal term, and is based on the individual's understanding of the court process and the ability to instruct his or her legal counsel. It is important to recognize that an individual can be psychiatrically impaired and still be deemed 'fit to stand trial'. Oftentimes, the decision is deferred, and the physician recommends in court the following day that the individual be remanded for a lengthier period of time at the Forensic Psychiatric Institute for a comprehensive psychiatric assessment. Individuals who are deemed 'fit' by the presiding judge are processed through the judicial system in the same manner as a non-psychiatrically impaired individual. That is, a trial takes place, a verdict is rendered, and sentencing or acquittal follows.

An individual who is found 'fit' following a period of psychiatric remand at the Forensic Psychiatric Institute, is returned to court and processed through the criminal justice system in the same manner as mentioned above. An individual who is found 'Unfit to Stand Trial' is returned to the Forensic
Psychiatric Institute for treatment and eventually returned to court when it is determined by his or her attending psychiatrist or the Review Board that he or she is 'Fit to Stand Trial'. Again, once 'Fit', the individual is processed through the criminal justice system as with the case of any other individual charged with a criminal offence.

There are many sentencing options. Some of them are: suspended sentence, fine, probation, a prison term and/or a combination of these. When an individual is sentenced to a period of incarceration, he or she is reviewed by a classification officer. The classification officer determines the appropriate correctional facility the individual should be placed in, based on the availability of the following information: the nature of offence, the past history of incarceration including past institutional behaviors, the recommendations of the court, past and current medical and psychiatric history and needs, the geographical home base of the individual, and so on. It should be noted that all the information may not be available during the initial classification stage; and certainly, inter- and intra-facility transfers occur depending on the emerging needs of the individual, and the availability of additional information, as well as institutional space and security demands.
Perhaps what is unique about the Lower Mainland Regional Correctional Centre is that, unlike other regional correctional centres, it does have a separate health care facility. As a result, inmates who require medical (including psychiatric) attention that can not be provided at the host institution, are often transferred to Lower Mainland Regional Correctional Centre. Sometimes, an individual who is certified under the Mental Health Act, and is awaiting a bed in the Forensic Psychiatric Institute may find himself in Lower Mainland Regional Correctional Centre. (This does not apply to female inmates as Lakeside Correctional Centre, located within the grounds of Lower Mainland Regional Correctional Centre, is the only female provincial correctional facility. The classification process is greatly simplified for the female population as there is only one facility. Female inmates can be transferred to Forensic Psychiatric Institute for psychiatric intervention.) Similarly, an individual may be returned from Forensic Psychiatric Institute to Lower Mainland Regional Correctional Centre instead of the host institution only if the latter is not equipped to meet the needs of the inmate.

In sum, how an individual enters the system, and where the individual ends up in the system are largely dependent on a multitude of factors. In addition, while the general political and economic climate influences our social policies, these
policies in turn, shape agency mandates, and provide individual caregivers the parameters of professional activities, including their discretionary powers.

CONCLUDING COMMENT

For the past four years, I have been actively involved with mentally ill offenders both within the local community and in our provincial institutions. During the Spring of 1987, I attended a local conference, the first of its kind, titled *The Mentally Disordered Offender*. All the speakers and participants at this conference, from federal and provincial, public and private sectors, identified the 'criminalization of the mentally ill' as one of the most alarming and demanding problems that challenges us today. Of concern to me, is the increasing number of mentally ill individuals who have been repeatedly arrested and incarcerated for offences that are symptomatic of their psychiatric illness. Moreover, I began to question whether the inherent limitations of the existing service agencies and social systems are creating a new 'career' path for our psychiatrically impaired patients.

Picture the following scenario: a "mental health traffic cop" directing individuals with mental illness from the hospital into the community. While some of these individuals manage to stay in the community, others return to the hospital again and again and again. As the community becomes less
tolerant and the hospitals become more restrictive in their admission criteria, some of our mentally ill patients who are caught in the 'over-flow' are being detoured into the criminal justice system; the only system that cannot say no. These individuals are subsequently labelled and categorized into the mentally ill offender group and are led into a 'career' option previously not readily available to them. And as if that is not enough, we furnish this group of mentally ill individuals with the context to stay within their new 'career' and little hope for change.

Several issues that have emerged for me during the past few years are: Is this group of mentally ill offenders different from the 'generic' mentally ill population? Does this added option of entering the criminal justice system contribute positively or constructively to the well being of the mentally ill individual? What are the negative consequences when we criminalize the mentally ill individual? How can we, as service providers improve or alter the current state of affairs? And finally, where do we go from here?
CHAPTER 3
THE RESEARCH DESIGN

This study was designed to gain an understanding of the concerns and needs of mentally ill offenders while they are incarcerated within a correctional institution. In this chapter, I will:

1) define 'mentally ill offender';
2) describe the purpose of the research study;
3) identify the issues selected for the research; and
4) describe the research methodology.

A short summary of the limitations of the design and the methodology will follow.

DEFINING MENTALLY ILL OFFENDERS

There is little consensus regarding the definition of the term 'mentally ill offender'. Monahan and Steadman (1983) identified four subgroups. These are:

1) those who are found Not Guilty By Reason of Insanity;
2) those who are found Unfit To Stand Trial;
3) mentally disordered sex offenders; and
4) mentally disordered inmates who are transferred to a mental hospital.

In his monograph The Mentally Disordered Offender, Halleck (1987) makes a distinction between the 'formally categorized'
and the 'non-formally categorized' mentally disordered offender. Basically, Halleck's first group embodies the four subgroups Monahan and Steadman identified. Although Halleck recognizes that the second group

"may share many characteristics with formally designated mentally disordered offenders...the two groups are managed quite differently by the criminal justice system...[That is,]...if they are treated the usual purpose is to alleviate their suffering or help them adjust to a particular environment. No specific legal purpose underlies their treatment, such as restoring their competency or rehabilitating them, and those who treat them do not usually report the progress to judicial agencies" (p.3).

He further comments that

"The routine of prison life and in particular the degree of isolation it imposes upon inmates allows seriously disordered offenders, including many who may be psychotic, to go undetected....My experience is not unique....If blatant psychosis can be hidden or undetected in prison, severe depression, which is much easier to conceal, is probably even more prevalent....If psychiatrists are available to examine individuals who frequently occupy punitive segregation units, they usually discover a high incidence of psychosis and major affective disorder....the personal vulnerabilities of many of these inmates in protective custody can be best described as manifestations of serious mental disorders....The number of these individuals eventually designated as mentally disordered offenders is unknown, but probably many are not" [sic] (pp.4-6).
For a much broader definition, Jemelka, Trupin, and Chiles (1989) use the term 'mentally ill offender' to mean "Those individuals in prisons and jails who have a diagnosable major psychiatric disorder (schizophrenia, unipolar and bipolar depression or organic syndromes with psychotic features)" (p.482) (my emphasis).

The Community Action for the Mentally Ill Offender (CAMIO), a non-profit organization in Seattle, Washington, describes its target population as

"any individual who, by virtue of a chronic mental illness, that is, schizophrenia and/or a major affective disorder, is unable to independently maintain law-abiding behavior. This includes those individuals who are in pre- or post-conviction status... either incarcerated or in the community".

For the purpose of this paper, the term mentally ill offender will not include those individuals who are found Not Guilty By Reason of Insanity, Unfit to Stand Trial, or Sex Offenders who do not have a major mental illness that is listed in the DSM-III-R, the official manual of nomenclature of the American Psychiatric Association. It is also not concerned with the group of mentally ill individuals who have been diverted by the arresting police officers into the mental health system. The group of mentally ill offenders this paper is referring to consists of individuals who have a major mental disorder that is found in the Axis I category of the DSM-III-R, and are either:
1) discharged psychiatric patients who have difficulties in coping with community living and are consequently processed through the criminal justice system for engaging in primarily minor petty crimes;

2) the emerging Young Adult Chronic Patients (See Appendix A) who are resistant to being categorized as mentally ill, and are therefore, similarly resistant to mental health treatment and social intervention. As a result, they are resurfacing amongst the criminal subcultures; and/or

3) offenders who become psychiatrically impaired while incarcerated or under community supervision.

Indeed, an individual with a major mental illness can 'fit' into more than one of these groups at any given time, or over time, as these groups are not mutually exclusive. I am interested in this group because it is the group that is most vulnerable to being lost in the system.

PURPOSE OF RESEARCH

In 1857, Edward Jarvis, an American psychiatrist, describes the experience of a mentally ill offender as follows:

"[He]...has nowhere any home: no agency or nation has provided a place for him. He is everywhere unwelcome and objectionable. The prisons thrust him out and the hospitals are unwilling to receive him; the law will not let him stay at his house, and the public will not permit him to go abroad. And yet humanity and justice, the sense of common danger, and a tender regard for a deeply degraded brother-man, all agree that
something should be done for him" (cf. Halleck, 1987, p.11).

In reference to Dr. Jarvis' comment, Halleck, a criminologist, clinician, and administrator, summarized the American conditions in 1987 as follows:

"These words still apply to mentally disordered offenders today. We remain uncertain how to treat them. We are unwilling to leave them alone, yet most agencies seek to avoid responsibility for their care. We confine them to prisons and to prison-like hospitals where they are sometimes treated worse than other offenders. They almost always receive worse treatment than mental patients in public or private mental hospitals" (p.12).

The availability of documented information within Canada, and specifically British Columbia, regarding the experiences of and with mentally ill offenders is very limited. Yet, there is an acute awareness amongst the direct caregivers in our health care, social services, and criminal justice agencies of both public and private sectors, that there is an apparent increase of mentally ill individuals who are emerging as a distinctive group in our local criminal justice system. The urgency to address the needs of this group of mentally ill offenders has been identified particularly by the Provincial Corrections Branch. In an unpublished discussion paper prepared for the Branch dated May 22nd, 1990, it was stated:

"it has become increasingly more common for correctional centre staff to comment on an increase in the number of MDOs [Mentally Disordered Offenders] in their institutions."
Correctional Service of Canada (CSC) has also identified the MDO as an area for concern and specialization. Community Corrections staff are under growing pressure to provide programming appropriate to these offenders" (p.2).

Furthermore,

"The Branch is experiencing pressure to provide services to a group of offenders that it feels ill equipped to deal with. In large part these offenders may be in gaol, not because of extensive criminality, but because of mental disorder. It, therefore, becomes difficult to reconcile services which have been designed for the 'average' inmate with the demands/requirements of the mentally disordered offender" (p.3).

**ISSUES SELECTED FOR RESEARCH**

In their review of the literature on mentally ill offenders, Jemelka, Trupin and Chiles (1989) pointed out that:

"Much more has been written about the legal issues in providing psychiatric treatment in jails and prisons than has been written about the treatment itself. Little is available in the literature to guide decisions about designing treatment programs" (p.485).

Given that there is a dearth of information regarding the experiences and needs of mentally ill offenders, this research study intends to:

1) explore the experiences of mentally ill individuals who have been incarcerated;
2) explore the problems that confront health care professionals and correctional personnel who provide care for mentally ill individuals who have been incarcerated; and

3) identify the needs of mentally ill offenders as perceived by themselves and their caregivers.

RESEARCH DESIGN

One way to determine the experiences and service needs of incarcerated mentally ill offenders is to ask them. Given the complexity of this topic area, a qualitative design was chosen. Such a design:

"attempts to gain a first hand, holistic understanding of the phenomenon of interest by means of a flexible strategy of problem formulation and data collection shaped as the investigation proceeds...understanding the system from the perspectives of the actors involved rather than through the imposition of the researcher's theoretical views" (Reid and Smith, 1981, pp.88-89).

In order to generate information from the point of view of the various actors involved, the study must be naturalistic and exploratory in nature. Naturalistic in this case meant that the research would be conducted within the correctional institution context; exploratory means that the intent "is to gain an initial look at a piece of reality and to promote ideas about it" (Reid & Smith, 1981, p.67).
With respect to data collection, the researcher felt it was important to

A) get close enough to be almost directly involved;
B) capture and record what actually happens in a non-judgemental manner;
C) record extensive descriptions of events; and
D) record direct quotes from all participants. (Patton, 1980, p.36).

The accumulated findings will be used to identify the problem areas of the existing services, and to facilitate future program planning and policy development, as well as to identify practical knowledge that can be applied in similar settings. Finally, through the process of Constant Comparative Methods as described by Glaser and Strauss (1967), a set of related concepts and hypotheses will emerge for future research studies.

By design, this study does not address the incidence and prevalence rate of mentally ill individuals who have been incarcerated. This research design is primarily exploratory and retrospective in nature.

**METHODOLOGY**

(i) DATA COLLECTION

Descriptive, qualitative data was collected by the researcher between March 1989 and March 1990, by means of
participant observation, supplemented with formal and informal semi-structured interviews. (See Appendix B) While some of the interviews were tape recorded, the researcher had to record in writing and summarize the important points made by some of the participants during and/or after the interviews since permission to be recorded was not always given.

The researcher used a "phenomenological approach" which included an informal unstructured conversational interview during the initial phase of the research study, followed by a formal interview using an interview guide, and then closing with specific open ended questions. In essence then, two interview procedures were followed - an initial informal interview as well as a guided formal interview.

(ii) SAMPLING

The sampling strategy was purposeful, rather than random. All subjects were approached in person by the researcher to determine their interest in participation. They were also selected, by the researcher, based on the premise that they would represent the various interest groups that might be affected by the criminalization process of the mentally ill.

There are two different sampling populations. They are:

a) mentally ill offenders, and
b) service providers.
Representatives from both groups are selected from the Health Care Centre of the Lower Mainland Regional Correctional Centre, as well as from the community. The mentally ill offenders group consisted of six male psychiatric patients -- four of whom were incarcerated at Lower Mainland Regional Correctional Centre at the time of the interviews, and two of whom were ex-inmates of the same facility. The service providers group consisted of health care professionals and correctional personnel. The health care professional group consisted of three registered nurses and one psychiatric nurse. The correctional personnel group consisted of one correctional administrator, one principal officer, and two correctional staff members—all of whom were from the Health Care Centre of Lower Mainland Regional Correctional Centre. In addition, this sample group included two health care professionals who were familiar with mentally ill offenders population as well as the correctional system, and two correctional officers from the Vancouver Pre-Trial Centre. (See Table 1) The total sample size was eighteen.
The sample was chosen as follows. With respect to the mentally ill offender population within the institution, the researcher began by asking the staff members to identify those inmates at the Health Care Centre who might have a history of mental illness. While some of them were known to the researcher already, in all cases there was the opportunity to review the relevant files. Following this, the researcher invited various potential participants to an individual 'get to know each other' interview with the researcher. Each individual was informed verbally and in writing (via the consent form, see Appendix C) the purpose of the research study. Each potential participant was aware that participation
was purely voluntary, and would have no influence whatsoever on his stay in the Health Care Centre of the Lower Mainland Regional Correctional Centre. Several mentally ill offenders within the community formerly known to the researcher were also asked in person if they were interested in participating in the research study. The purpose of the study was explained to them verbally and in writing. Arrangements were made to meet them in the community, and the interviews took place in the office where the researcher had previously worked.

With respect to the selection of service providers within the Health Care Centre of the Lower Mainland Regional Correctional Centre, the researcher spent an initial block of time just to get familiar with their roles and the structure of the institution. Informal discussions provided the opportunity to identify those staff members who might be suitable and interested in participating. (Individuals who were unfamiliar with the correctional system and/or the Health Care Centre either because they were recently hired, temporary relief, and/or auxiliary status were considered unsuitable candidates.) Each staff member was informed verbally and in writing (via the consent form, see Appendix D) regarding the purpose of the research study. Again, each was aware that participation was voluntary, and confidentiality would be respected. In addition, several correctional officers and health care workers within the community formerly known to the researcher were
asked if they were interested in participating in the research study. Arrangements were made to meet them in the community, and the interviews took place either in their office or the offices where the researcher previously worked.

(iii) THE INTERVIEW

An open-ended semi-structured interview guide (See Appendix B) was designed by the researcher to ensure that the same general topic areas would be explored during the formal interviews. Such a guide permits flexibility, detailed probing, and the opportunity for expressions of personal attitudes, experiences, perception, and ideas. Information gathered from the early interviews was used to ask more succinct and pertinent questions in the subsequent interviews.

(iv) DATA ANALYSIS

The raw data consists of: six tape recorded interviews transcribed verbatim by the researcher, and information collected from twelve interviews, recorded in writing by the researcher, since permission to record by tape was refused. The information collected from these interviews was used as basic concept indicators and subsequently used for comparisons with the rest of the field notes. (For details of the analytic process, see Appendix E).
The analytic process used accommodates the individual preferences of the participants. In an ideal situation, it is the opinion of the researcher that all interviews should be tape recorded. This would allow closer adherence to Glaser and Strauss' Constant Comparative Method where verbatim, sequential line-by-line coding, memoing and analysis would be maintained; and the degree of subjectivity on behalf of the researcher would greatly diminish. That the modified version of data collection was not a 'pure type' is acceptable as "In practice any particular evaluation may employ several...strategies or combinations of approaches" (Patton, 1980, p.205). After all, the strength of qualitative research is the ability to accommodate the individuality of the subjects and still be able to gather a relatively uniform body of relevant data. In short, the researcher considers the data collection methods used were optimal for the circumstances, and have yielded valid data.

(v) ETHICS

This research study was approved by the University of British Columbia Research Screening Committee as well as by the Ministry of Solicitor General, B.C. Corrections Branch. All interviewed participants were required to sign a consent form and were informed of their right to decline participation if they chose, as well as withdraw their consent to participation at any time during the interview(s). Their identities remained confidential and all identifying information has been destroyed.
(vi) DISCUSSION

Some of the limitations of this study are as follows:

1) The sample size of eighteen limits the generalizability of the data. In addition to a larger sample size, obtaining data from inmates of the 'general population', ethnic minority groups who are also mentally ill offenders, and female mentally ill offenders, would be useful in terms of identifying similarities and differences of service needs between the different groups. In an ideal situation, obtaining data from hospitalized psychiatric patients, again in comparing the similarities and differences, would also be quite illuminating. The use of comparison between the different data would elucidate the problems and needs presented by mentally ill offenders. The pursuit of such studies in the future is strongly recommended.

2) The research study was conducted within the Health Care Centre of a medium and maximum security correctional institution within the Lower Mainland. The results of the data analysis apply therefore only to this setting, and have limited utility in a different setting, rendering the conclusions useful only in generating hypotheses for future research studies. The conclusions are important primarily because of the conceptual significance, particularly in identifying salient variables for future studies.
3) One of the extraneous variables that must not be ruled out, given the non-randomness of the sample selection, is the phenomenon of 'demand characteristics'. That is, when researchers "wittingly or unwittingly give subjects cues about how they are supposed to behave" (Kidder and Judd, 1986, p.97). Furthermore, voluntary subjects "are particularly likely to respond to signals and demands they perceive in the experimental setting" (p.97). Although the authors note that the "potential is greater in randomized laboratory experiments" (Ibid), the issue remains that individuals who have a different attitude or perspective may decline to participate. In addition, institutionalized psychiatric patients tend to be either eager to please or resistant when they interact with 'system representatives', leaving one wondering how much of what they say is a function of institutionalization. In other words, telling the researcher what one thinks he or she may want to hear. As a result, the self-selective process could conceivably skew the types of data obtained, and not represent the full reality of the area of interest.

4) At the time of the study, the B.C. Ministry of Solicitor General, Corrections Branch, has been in the process of decentralizing the Lower Mainland Regional
Correctional Centre. As a result, there has been a great deal of uncertainty with the impending re-shuffling of staff members. This undoubtedly had influence on the staff morale, the political context of the study, and the general interest in participating in the study.

5) Several new programs were brought into the Health Care Centre during the Spring of 1989, shortly after the researcher had started her study. They were: a social skills group, an alcohol and drug program, and a community based program, (the Inter-Ministerial Project). As well, the researcher herself, at the request of some of the staff members, brought in articles on behavior management. While some of these programs were more enduring than others, they all in part, had an impact on the institution, the mentally ill offenders, and the staff. It may well be that the participants in this study were more articulate in terms of identifying what they perceived the needs to be since those programs were still fresh in their memories. To see the programs actually operating might have influenced their perceptions regarding the feasibility and desirability of implementing certain programs within a correctional setting.
Notwithstanding the abovementioned limitations, it was decided that the research design and methodology were appropriate.
As stated in the previous chapter, the data collection consisted of two methodological processes - the informal participant observation and the formal guided interviews. As with other studies of a qualitative nature (See Appendix E), the findings can only be fully understood in the context in which the study took place and through understanding the process by which the findings were generated.

CHARACTERISTICS OF THE SAMPLE

Readers should refer to Table 1 for further clarification.

(i) mentally ill offenders

Altogether, six mentally ill offenders participated in the formal data collection of this study. Of the six participants, four were inmates serving their jail sentence at the Health Care Centre of the Lower Mainland Regional Correctional Centre at the time of the study and two were ex-inmates of the same facility, who were residing in the community at the time of the interviews. It should be noted that none of the participants of this group was acutely psychotic at the time of the interviews.
The age range of the mentally ill offender group falls between mid-twenties and mid-forties. All are single men, who have never been married. Several other commonalities that this sample group share are:

1) a diagnosis of mental illness in the categories of Axis I and Axis II as per the Diagnostic Statistical Manual, Third Edition, Revised;
2) multiple psychiatric hospitalizations;
3) multiple contacts with police officials including provincial jail sentences;
4) a history of substance abuse;
5) periodic contacts with local community mental health centres;
6) a long history of unemployment; and
7) have been receiving Income Assistance for most, if not all, of their adult lives.

(ii) service providers

Altogether, twelve service providers participated in the formal data collection of this study. Of the twelve participants, six were correctional personnel and six were health care professionals.
(a) correctional personnel

Of the six correctional personnel, all were male. Four were employed at the Health Care Centre of the Lower Mainland Regional Correctional Centre at the time of the study, and the remaining two were employed at a different correctional facility at the time of the interviews. The length of years in experience ranged from a minimum of five years to the maximum of twenty-five years. This group brought to the research study a variety of experiences within the correctional system, including front line custodial work, case management, classification, unit management, administration, program planning, and policy analysis.

(b) health care professionals

Of the six health care professionals, four were employees of the Health Care Centre of the Lower Mainland Regional Correctional Centre at the time of the study. They comprised of two female registered nurses, one male registered nurse, and one female psychiatric nurse. As for the remaining two male health care professionals, one was a psychiatrist on contract, and the other was a community mental health social worker. The length of years in experience ranged from a minimum of nine years to the maximum of thirty years. This group of health care professionals brought to the research study a range of
clinical experiences within the correctional, medical, and mental health systems.

All the participants in this sub-group worked with mentally ill offenders either during their period of incarceration and/or when they were residing in the community.

FINDINGS AND DISCUSSION

I. Alienation

A primary finding that emerged from this study is the sense of alienation shared by all the participants.

Alienation, as defined in the Webster's New Collegiate Dictionary is the act of withdrawal, detachment, and separation. To alienate is to feel estrangement, to disconnect, and to distance from the self and/or the external environment. It can be achieved through insulation by the self or isolation by the external world.

(i) mentally ill offenders

Individuals who suffer from major chronic mental illnesses such as schizophrenia and affective disorders (Axis I as per the DSM III-R) often experience a form of displacement. This is because mental illness intrudes upon the individual and
mounts up a psychological barricade that separates the individual from his or her own self and the external world. As is indicated in the following examples, mentally ill individuals are oftentimes left with an existential void or a sense of emptiness.

"I don't really know how I feel sometimes. It's like I can only stare you know. There's no thoughts going on in my head."

"I don't get the audio hallucinations anymore. I miss that. It was my life. It was what I built my life around. Without that, I don't have my life anymore."

In the same vein, a health care professional who participated in this study made the following observation:

"The impression I get is that they are chronically neutral about everything... It's like they are fighting against this condition that's a psychological vacuum that sucks all the life out."

What emerges then, is a sense of detachment, as one becomes more isolated and withdrawn. **Withdrawal,** assumes different forms. Take the following for example:

"I used drugs a lot to escape from reality";

"I've cut other people out of my life";

"I don't want to steal. I'm not a thief"; and

"It became an excuse for me to cop out."

Withdrawal, be it into drugs, one's self, or the criminal subculture, inevitably leads to further insulation,
estrangement, and despair. In order to cope with the sense of disconnectedness and helplessness, the mentally ill individual feels increasingly indifferent towards him or herself and the external environment. This is best illustrated by the following examples:

"I couldn't do anything. I never tried. As an individual, I'm a failure"

"Jails and hospitals are places for me to hide. Hide from myself and other people....They become like hotels....Being in jails and hospitals broke up my time";

and

"I can't envision anything different or what I want because if there is something I want, it may give me the motivation to go out and get it".

As part and parcel of the sense of helplessness, there is a passive acceptance of the external world regardless of how unsatisfying it may be. The lack of hope, despair, and the absolute passivity are evident in the following narrations:

"It was hard. I was there, being the end of my life. This is what my life had come to. I thought it was the end";

"Here, I get up and have breakfast, and get back to bed. I get up around ten or ten-thirty, maybe have a shower, and then have lunch. Then I play cards, crash out for awhile, get ready for dinner, maybe read a bit or write something down. Just phone numbers, make sure I don't lose them, that's all";

"I see the psychiatrist once a week or once every two weeks. Actually, no, I see the psychologist. I don't know what you can get
out of a three minute conversation, but it seems to be alright. I walk in there and he goes, How are you Mr. _________. I say fine. How did the medication go? O.K. Well, we'll keep you taking the medication until you get out. That's it! Then he says next! And you just go back upstairs again"; and

"Well, it's just the way life is. It's only who you come into contact with. Well, how people react to you. Favourable or not"

The onset of mental illness is often an insidious process. From my clinical experience, early warning signs such as social withdrawal and isolation, poor coping skills, poor interpersonal relationships, self-medication through alcohol and illicit drug use, an inability to maintain employment, are often overlooked, tolerated, and/or dismissed by the individual's family, friends, and social network. In other words, many mentally ill individuals' premorbid psychosocial functioning, in retrospect, may be considered at best marginal. This is further exacerbated by the disease process.

In sum then, individuals with mental illness often lack the motivation and the capacity to develop the social and life skills necessary to cope effectively. They also experience great difficulties in communicating with their family, friends, social network, and caregivers. The inability to express their feelings and their needs can be stressful, and in turn, creates estrangement and encourages social withdrawal. Their lack of social competence alienates them and fosters a sense of
helplessness which compromises their quality of life, leaving them all the more vulnerable to another relapse of their illness. All the mentally ill offenders who participated in this study gave evidence of this process.

(ii) correctional personnel

In review of the findings, and particularly in view of the researcher's identification of alienation as a major issue, some further elaboration on the context of the study and the process by which the study was conducted is required.

At the time of the study, a number of changes were taking place within the correctional facility.

1. A noticeable loss of senior correctional staff members to the provincial government's early retirement program; resulting in

2. a high staff turnover; and

3. an increased use of auxiliary on-call auxiliary staff members.

In addition, the Provincial Corrections Branch was working on its long term plan of 'regionalization'. Regionalization meant the systematic closing down of the existing Lower Mainland Regional Correctional Centre and the development of smaller
local correctional centres. As with any major re-organization, informal discussions and 'rumors' were rampant and there was a sense of uncertainty in the air.

Although I have spent time at the Health Care Centre before, and the staff had generally been friendly towards me, a great deal of time was spent on engaging the correctional staff members. It became apparent that a formal approval from management (See Appendix F) was required if I was to carry out the research study with the least amount of suspicion and the greatest degree of cooperation. Essentially, the authorization memorandum gave staff members the formal permission to disclose information to the researcher. The researcher wore two hats; one that of a student and the other, of an individual with professional expertise in the field. The 'student' role was useful as it encouraged the staff members to share their knowledge with the researcher. The 'professional' role was useful as it allowed the researcher to be supportive and empathic, which minimized some of the distrust on the part of the correctional personnel. Even then, a lot of effort was required to assure the staff members of their anonymity. The fact that I was a Social Worker meant that I remained a suspect to some. In order to obtain the data for my study, I had to concede to some interviews without a tape recorder and on two occasions, I was sworn to secrecy and had to promise that I would not share the information with the 'nursing staff'.
The physical structure of the building and the nature of custodial work demand that the correctional personnel remain at their work sites. Therefore, geographically, they were separated. For example, one staff member is positioned by the front gate, two in the 'control centre', one in the adjoining office who is responsible for Units one and two, two upstairs who monitor the inmates from Units three, four, five and six, one in the basement who monitors the work program, and a couple of others who serve as escorts.

What became apparent was that the physical separation of correctional personnel from one's peers, the health care professionals, and the inmates, discouraged communication and information sharing. For example,

"Their files are scattered in four different places. I don't know what the problem is";

"Sometimes, an inmate would ask me about what's out there for them, I don't know what to tell them. I know there's a Red Book, and put together a resource book, but they're kept in the nursing office, I think. I haven't seen it for a long time, we should have one up here"; and

"We don't even have time to talk to each other between relief".

In short, the lack of reciprocal exchange led, in the case of the correctional personnel, to the development of psychological divisiveness, and alienation, not unlike the experience of the mentally ill. What occurred was that the
correctional personnel withdrew into their own 'camp' and the distance allowed them to become detached. Some of them further insulated themselves by strictly adhering to the Rules and Regulations of the facility. This is best illustrated by the following comments:

"Our priority is security"; and

"The correctional perspective is the final perspective"; and to a lesser degree,

"It's a good thing we have some discretion, or else every time we turn around they'll be charged with something".

In the process of withdrawal then, the correctional personnel can be deemed to have alienated themselves from the mentally ill inmates. And as the 'gap' widened, what emerged were fears and frustrations towards this group as well as a sense of powerlessness. There are many examples:

"I don't know enough to know if they're sick or if they're cons....I can't talk to them the same way".

"I don't know what to expect! These guys can be quite unpredictable";

"This group's hygiene is generally very poor. They don't take care of their living area";

"I'm not like you, I don't know why they're the way they are"; and

"They make working here dangerous. I'm more concerned with my own safety. As far as I'm concerned, the correctional officers are put at risk".
How the fears and frustrations of the correctional personnel impact on the mentally ill inmates is captured in the following comment made by one of the participants in the mentally ill offender group:

"They make fun of me. People. They laugh at me at Oakalla. I prefer the old guards 'cos they're good to me. They give me tobacco, they leave me alone. The new guards, sometimes they make fun of me. Is it wrong to hear voices?"

Also, some of the correctional personnel felt overwhelmed by their sense of powerlessness and helplessness and felt unable to create positive changes. This is evident in the following:

"These guys don't belong here, but they keep coming back!";

"I'd love to be able to do more than just this, but if there's not enough staff, it's just no way";

"I'd like to be involved with the programming....I would enjoy it but the problem is the lack of staff";

"I've asked for training before, but I won't do it on my own time"; and

"What you see here is the revolving door syndrome. A lot of guys have been here before!"

Based on the information I have gathered, it is apparent that the training of correctional personnel is largely limited to the Rules and Regulations of the Corrections Facility Act,
and the various security measures and procedures available to maintain order and control. The basic training speaks to the issue of psychopathology to a very small extent, and does not address the nature of mental illness, the signs and symptoms of mental illness, or how to deal more effectively with the mentally ill. It is not surprising then, that the lack of knowledge in this area would rapidly lead to fears, frustrations and disengagement.

Isolated, correctional personnel would naturally feel compelled to use what skills they do have to make their daily routine less threatening. Moreover, the correctional environment becomes fertile ground to breed resentment, passive resistance and alienation when expressions of motivation to learn more information or to try out different skills are discouraged or curtailed.

(iii) health care professionals

Again, in considering the findings, it is necessary to take into account the context of the study and the process used to generate the data.

At the time of the study, the one major change that occurred for the health care professionals was that their hours of operation were cut back from a twenty-four hour service to a
seven a.m. to eleven p.m. schedule. This loss of working hours resulted in:

1) a cut-back of staffing;
2) an increase in work load; and
3) fewer opportunities for communication.

In addition, there was an anticipation that the plan of 'regionalization' might mean that the health care component of the Provincial Corrections Branch would be contracted out. Again, there was a sense of uncertainty in the air.

My presence at Health Care Centre was greatly welcomed by the health care professionals for one primary reason. That is, they perceived me to be a resource for them, and their peer. They were aware that I was familiar with many of the mentally ill inmates, I was able to share information with them, they were able to consult with me for ideas on management issues such as discharge planning, community resources, etc., and I was able to spend time with the inmates when they were not able to do so. Whenever possible, they involved me in their activities and they paved the way to make it easier for me to conduct my research.

The nursing office is located on the main floor of the building. Adjacent to this is the medical examination room, both of which were quite enclosed, away from the rest of the activities of the facility. Contacts with the correctional
personnel were largely limited to a public announcement system, when inmates were escorted to and from the nursing office, and when the nursing staff was escorted through the various units to dispense medication.

While there is no physical separation of the health care professionals from their peers as there is only one nursing office, there is a physical separation from the correctional personnel and the inmates. A case in point is provided in the following comment made by one of the health care professionals who participated in this study:

"I don't work with the correctional staff. I have very little dealings with them".

An even more poignant example was an observation made by one participant who was working in the community with mentally ill offenders at the time of the interviews:

"The only attention people get is when they have medication, or, if they have a medical problem. Otherwise they don't get any attention at all".

Again, the distance turned into a psychological detachment, and the health care professionals, as a group, can be seen as insulated from the correctional personnel and the mentally ill inmates. In the process, they can become frustrated and withdraw into their framework of reference, the medical model.
For example:

"All I do is paper work, not patient care!";

"I'd love to spend more time talking to these guys, but I have too much paper work to do"; and

"I work in a place that is philosophically against rehabilitation".

**Frustrations** turn into **detachment** and a sense of **powerlessness**. This is illustrated in the following examples:

"I was trained as a RN, not a psychiatric nurse...I don't know that stuff very well. I only took one course in psychiatry and that was a long time ago";

"I think the [correctional] staff who deal with these guys on a day to day basis should get more training. They don't have any and some of the ways they handle these guys are, are abysmal! I take the time to tell them sometimes, but it's not my job";

"There's no social work staff unfortunately who could coordinate discharge planning and so many other things for the mentally ill...There should be on-site social workers whom I can liaise with, help for housing and follow-up and stuff like that";

"The impression I get is that they [the mentally ill] are chronically neutral about everything....It's like they are fighting against this condition that's a psychological vacuum that sucks all the life out"; and

"sometimes when I see the way they [correctional staff] handle them [mentally ill inmates]...they treat them like the other guys and they're not! And then they get upset because they don't respond the way they should".
The degree of estrangement and alienation between the health care professionals and the correctional personnel was explored by a senior correctional staff member who participated in this study. He states:

"As a general statement, yes, there are tensions between the correctional security officer's view of how things should operate as compared to the nurses....it does take awhile to work through that understanding, and basically the use of authority and power...Until he or she has made that accommodation to be able to use that authority well, there may be an acceleration or an increase of those kinds of tensions".

Based on the information I have gathered, it appears that the amount of formal training the health care professionals have in the area of psychiatry varies. For some, their training took place on the job. Naturally, this would lead to a varying degree of fears, frustrations, and strict adherence to the medical model. The opportunity to communicate and share information is compromised by the demand and the burden of paper work, and in turn, perpetuates the detachment, the insulation, the sense of powerlessness, and the sense of alienation already remarked upon.

DISCUSSION

In summary then, common threads of meaning were discovered between the three groups of participants - mentally ill offenders, correctional personnel, and health care professionals. Through the process of content analysis emerged
as a major theme **alienation**. **Alienation** is characterized by estrangement, detachment, separation, withdrawal, distance, insulation, and isolation. Although the causes, the precipitating factors, and ultimately the solutions may vary, what is important is that the personal experiences and the process with which we deal with these experiences, are alike for the three groups, and therefore can be presumed to support one another; in other words, to reinforce the pathological processes already at work in mental illness.

**IMPLICATIONS OF THE ALIENATION FINDING**

The above findings highlight some of the problems experienced by the mentally ill offenders, the correctional personnel, and the health care professionals who participated in this study. The implications with respect to program planning are many.

(i) mentally ill offenders

Some of the problems mentally ill offenders encounter prior to, during, and subsequent to their term of imprisonment are social isolation, homelessness, substance abuse, amotivation, denial of the illness, the lack of vocational opportunities, the absence of meaningful interpersonal relationships, the inability to obtain the required services, and the sense of powerlessness and alienation.
Any efforts to provide this group with the opportunity to successfully re-integrate into the community and improve their quality of life would therefore seem to demand a variety of programs. Some of them are: occupational therapy, pre-employment training, work programs, job search, symptom awareness and management, resource awareness and access, life skills, communications, substance abuse counselling (which incorporates the concept of dual diagnosis), interpersonal relationships, money management, recreation and leisure development, assertiveness training, and anger management, to name a few. Even more important however, is that the programs must be designed:

1) to motivate;
2) to engage; and
3) to empower

this group rather than waiting for them to become motivated spontaneously.

(ii) service providers

Some of the problems the group of service providers encounter are: a geographical separation, the inability to access information regarding the inmates, the lack of communication amongst peers, the lack of an interdisciplinary approach to patient care, the unavailability of adequate resources, the lack of knowledge base and training, the sense of isolation, and the lack of organizational support.
Efforts to facilitate the optimum use of the staff expertise and the development of job satisfaction must address these problem areas. For example, a redesign of the physical structure of the facility could promote the development of a therapeutic community. This would address the need for a central area that contains all the information regarding the inmates, intra- and inter-professional communication, and a team approach where information can be shared. There must be both initial orientation and in-service training that would address the following: the nature of mental illness, how to identify and recognize the positive and negative symptoms of the major mental illnesses and the various personality disorders, the unique needs of the mentally ill, and how to work more effectively with this group without compromising security. In addition, management may wish to consider adding a social work position to the organization. A social worker would offer significant contributions in the areas of release planning, program development and implementation, and the 'bridging' of the health care professionals and the correctional personnel. Finally, for changes and program implementation to be successful, staff members must have a sense of ownership. They must be viewed as an important resource and be involved and be consulted in the process. Non-involvement clearly contributes to the feelings of helplessness and despair graphically described by the research participants.
II. Organizational Commitment

A second major finding that emerged from this study for the researcher is the evidence of a lack of organizational commitment in providing services for the mentally ill population within the correctional health care setting.

Commitment, as defined in the Webster's New Collegiate Dictionary, is the state of being obligated and emotionally compelled to do something. It is the agreement and the engagement to assume a responsibility. It contains two equally important dimensions. The will and the act.

As stated in an earlier chapter (See Chapter 2), a number of programs were available during the time when the study was conducted. They included a work program, an alcoholics anonymous group, a spiritual guidance program, a social skills group, an alcohol and drug treatment group, and a research study of an intensive case management program from the community. Efforts were made by the researcher to learn about the content as well as the 'mechanics' of these programs.

The researcher attended some of the social skills, and the alcohol and drug treatment groups. Informal interviews with the 'leaders' who were involved as well as formal interviews with the inmates who attended them were conducted. In addition, part of the informal and formal interviews with the
service providers focused on the desirability and the viability of these programs.

What became evident from the informal interviews was that the 'leaders' of the groups were contractors from external agencies. The contract agreements with the Provincial Corrections Branch were intended for the whole Lower Mainland Regional Correctional Centre, the Health Care Centre notwithstanding. The 'leaders' were experienced in working with offenders/inmates, not offenders or inmates with mental illness.

Informal interviews with the service providers, indicated to the researcher that there was very little awareness of these programs. This is demonstrated by the participants' lack of knowledge of the groups' existence, their lack of knowledge of when they occur, and their lack of knowledge as to which inmates were attending. Furthermore, it was a consensus that although these programs might be useful for the inmates, they could only accommodate the inmates' participation providing there were enough staff members available to ensure security.

The following observation, made by a health care professional who participated in the study, summarizes the reality of program design and implementation within the Health Care Centre quite accurately. He states:
"every now and then, I think they have had programs...they seem to be sporadic, no one is quite sure when it's gonna happen or if they happen. They seem to happen for a month or two and then they stop, and then they happen again a couple months later. I assume that that's because they contract these jobs out. They'll work for awhile, and then their contract would run out. Then they'd start out again. Someone else will start another one. There doesn't seem to be any sustained program, and the people are sitting there doing time, hour after hour, with very little to do".

To be fair, interviews with the mentally ill inmates revealed a relatively positive attitude and response towards these programs. They can be summarized by the following comments:

"I was glad to know that people care, and that other people had the same problems. Actually, I looked forward to going...I wish it was longer. I think they should have more of that, more programs like that"; and

"We need more programs to help us. Here's a lot of people who are in a lot of trouble that want to get straightened out. They just need some help. It'll get the time go by faster too".

The discrepancy between the lack of sustained programs and the expressed interest in participating in programs by the mentally ill offenders can be better understood in the context of the following comments made by a senior correctional official and a senior health care professional, both of whom participated in the study. They are as follows:
"The jail environment, over the last years, have not been program development or attempting to treat. So providing the structure program that has treatment as one of the goals, Corrections just hasn't been conducive to that"[sic];

"Corrections do not see themselves as a hospital treating psychiatric patients. So, to say I want to design some sort of treatment program for psychiatric patients, I think, runs contrary to what they see themselves as"; and

"I think it is philosophically an issue. It's either a prison or it's a hospital....I mean, we can get into a whole personal view of rehabilitation to begin with. I mean, I think it costs us thousands of dollars more than it should because we don't properly train people. I don't see why we can't train people. They sit in their cells twenty three hours at a time, doing nothing. It doesn't make any sense, it's ridiculous...So, if you're not gonna train them, if you're not gonna treat them, if you're not gonna help them with job finding or anything like that, it's so simple in its concept! There're so many people I see who can benefit so much from some type of job program, some job search, that they can benefit from or look forward to when they get out. Not everyone in prison is hopeless. Not in our eyes anyways. I work in a place that is philosophically against rehabilitation".

In summary then, the Health Care Centre of the Lower Mainland Regional Correctional Centre did offer some programs to their inmates. However, these programs were not an integral part of the facility, nor were they designed specifically for the mentally ill population. Although they were found to be useful and were appreciated by the mentally ill inmates, the
'ad hoc' nature of the programs raised some very important issues for the researcher. The primary one was how the way such programs are implemented plays a role in fostering the pervasive sense of alienation expressed by the various participants of the study. Also, the organizational commitment to the act of providing services that are sensitive to the needs of the mentally ill is clearly unsystematic, haphazard, and vulnerable.

**DISCUSSION**

All formal organizations such as the B.C. Corrections Branch, are guided by their mission statements. The mission statement indicates the guiding philosophy or superordinate goal and conveys the organization's overall purposes. It provides a framework that lends "continuity to the organization over time by serving as a focal point for strategy formulation and the application of individual and group work efforts" (Schermerhorn, 1984, p.150).

In their *Beliefs, Goals, and Strategies* publication (Queen's Printer, revised 1986), the B.C. Corrections Branch identifies one of its primary mandates as: to **carry out the sentences imposed by the courts**. It is stated that sentences are based on five principles. They are: retribution, rehabilitation, deterrence, incapacitation, and reparation. For the purposes of this paper, the following discussion will focus on the principle of rehabilitation only.
As stated in their document, one of the mandates of B.C. Corrections Branch is to provide sentenced offenders:

"reasonable opportunity for positive and constructive activities within operational and resource limitations and consideration for the protection of the public... correctional programs [should] provide opportunities for work, social, educational, and recreational activities and spiritual development. Offenders are encouraged to take advantage of these opportunities....When offenders admitted to correctional programs require treatment for medical, physical, or psychological problems, the branch provides appropriate treatment or makes community health resources available to them. Although rehabilitation does occur within correctional programs, the programs alone cannot rehabilitate offenders. While programs can encourage behavioral change, rehabilitation is the responsibility of offenders themselves" (my emphasis) (pp. 5-6).

Opportunity, as defined in the Living Webster Encyclopedic Dictionary, is a convenient or favorable position or chance. Chance is defined as an event occurring without apparent cause or control; a purposeless cause of unexpected happenings; a possible or probable occurrence.

According to Cormier (1989), the demise of the rehabilitation concept within correctional services was sparked by the infamous paper written by Robert Martinson in 1974 titled Nothing Works! The title of this article speaks for itself. Although this was an American publication, its influence on the Canadian Correctional system was profound.
Thus, Cormier states: "Ironically, Martinson's controversial article appeared at a time when rehabilitation was beginning to occupy a stronger position in the Canadian Penitentiary Service" (Cormier, 1989, p.7). By 1977, the Canadian Federal Corrections Agency Task Force recommended that the 'rehabilitation model' be replaced by the 'opportunities model'. That is, the correctional system would

"provide correctional opportunities designed to assist the offender in the development of daily living skills, confidence to cope with his personal problems and social environment and the capacity to adopt more acceptable conduct norms" (Ibid, p.30).

The B.C. Corrections Branch maintains that their program, policy, procedures, and services rendered are guided by a set of values and beliefs. Included in their set of beliefs is the provision of

"opportunities for inmate work, education, recreation, life-skills and spiritual development that

a) encourage responsible personal decision-making; and

b) contribute positively to the individual's quality of life, to the branch, and to the community" (p.10).

Furthermore, it is responsible for the assurance of the "availability of medical, dental, and psychiatric services comparable to those generally available to the public" (my emphasis) (Ibid).
Essentially, the disenchantment with the rehabilitation model had led to a shift in the goals of our provincial correctional services. **Emphasis is placed on the personal initiative of individual inmates to take advantage of the opportunities made available to them.**

As observed by several participants of this study, program development for mentally ill offenders has not been a priority within the Provincial Corrections Branch during the past decade or more. Other contributing factors such as: the fiscal constraints; the heterogeneity of the inmate population; the nature of mental illness itself; and the sentiment that mentally ill individuals do not belong in the correctional system; all play an active role in discouraging the provision of psychiatric services to mentally ill offenders.

Together, all these factors translate into the introduction of sporadic, time-limited programs managed by outside contractors who may or may not be fully oriented to the needs of mentally ill offenders. When the existing staff members who interact with the mentally ill offender the most are not provided with the necessary training, are not involved and are not consulted in program development and implementation, the possibility of developing a therapeutic milieu is precluded. When programs implemented by outside contractors are not reviewed and evaluated for their relevancy, and efficacy, the
contractors are not held accountable. There are no safeguards in place to ensure that the contractors deliver their services ethically. Furthermore, time-limited contracts do not command commitment on the part of the contractors.

When programs are unavailable, inaccessible, and/or non-accountable, one is left with the sense that the Correctional Services have taken a clear departure from the 'opportunities model' to an 'on the off-chance model', where mentally ill offenders have very slight hope of even taking advantage of substandard programs that are haphazardly structured and implemented. To imply that these services are comparable to those available to the general public is rather alarming.

**IMPLICATIONS OF THE ORGANIZATIONAL COMMITMENT FINDING**

Given that the 'opportunities model' is the stated predominant guiding philosophy of the B.C. Corrections Branch, the following section will examine how this model is applied at the Health Care Centre of the Lower Mainland Regional Correctional Centre, with specific focus on its application to the mentally ill population.

To begin with, it could be said that the mentally ill offender has the opportunity to be placed in the Health Care Centre while serving the duration of the sentence. This,
however, depends on whether there is a bed space available. Availability is dependent on the number of inmates from the general population who may require medical attention, the level of functioning of the other mentally ill offenders, and the criminal justice history of the individual.

Secondly, the mentally ill offender has the opportunity to obtain psychopharmacological treatment on a voluntary basis. However, if he becomes floridly psychotic, delusional, paranoid, and is unable or unwilling to consent to treatment, he will remain dangerous to self and/or others without the benefit of medical intervention until transferred to a psychiatric facility such as the Forensic Psychiatric Institute. Meanwhile, the mentally ill offender has the opportunity to be subjected to the humiliation of open scrutiny by the fellow inmates, staff, and visitors of the Health Care Centre. It should be noted here that the inmate at this time is usually semi-naked, partially shackled, and engaging in 'creative' activities such as smearing feces on the wall.

For the quiet psychotics, or the passively withdrawn individual who is clinically depressed, there is the opportunity to experience the lonely disease or dysphoria in isolation. These individuals have the opportunity to be vulnerable to abuse and be preyed upon by other inmates. This
group is easily overlooked since they are non-disruptive; unless they attempt suicide, of course.

For the mentally ill offender who is either stabilized on medication or whose mental illness is in remission, there is the opportunity to see the psychologist for at least a "three minute conversation", or talk to the nursing staff as long as the staff member does not "have too much paper work to do". The mentally ill offender also has the opportunity to take advantage of utilizing the correctional staff members as a resource to take personal responsibility for his rehabilitation. This is possibly therapeutic and encouraging for the mentally ill offender. That is, the opportunity to find out that the only resource person that is available to assist him in setting up linkages with the community knows as much, or less, than he does.

This group also has the opportunity to take advantage of the 'work program' providing that there are positions unfilled by the non-mentally ill offenders, and the individual is not a 'security concern', and has some basic skills. Mentally ill offenders who do not have the necessary experience have the opportunity to seek asylum in their cells and eat, sleep, and look forward to returning to the community with less confidence in their abilities to survive, and wait.
As all sentenced inmates of the provincial correctional system receive a determinate sentence, all inmates have the opportunity to leave without completing the programs they may be involved in. Furthermore, they have the opportunity to leave the facility, for example, on a long weekend, and have no sense of how they can obtain basic food and lodgings when most of the services are not available, or "what happens ten minutes later". Unlike the patients in a psychiatric facility, mentally ill offenders have the opportunity not to remain in the Health Care Centre voluntarily, or completing the programs on an out-patient basis. Instead, mentally ill offenders have the opportunity to return to the community more ill prepared, and without the benefit of 'release planning'.

**SUMMARY**

The basic premise of the 'opportunities model' is that the inmates are rational and purposeful beings who only require minimal encouragement to take advantage of the available services, and take personal responsibility for their rehabilitation. This model does not apply well to the needs of an inmate who may be psychiatrically impaired, with possible cognitive and social deficits. In fact, it neglects some very important features of their illness. The reality is, many of our chronic mentally ill patients lack the personal capacity and social competence to seek out or initiate interpersonal contacts. Their impoverishment leads to limited behavioral
repertoires, social isolation and withdrawal, and finally the exacerbation of psychiatric symptoms. One can only surmise that, left to their own devices, mentally ill offenders are unable to thrive or flourish under the 'opportunities model'. Programs that do not emphasize consistency, continuity, efficacy, availability, and accessibility are not opportunities. At least not for the chronic mentally ill population.

III. Where Do They Belong?

A third theme that emerged from this study for the researcher is the question of whether mentally ill individuals belong in the correctional facility.

Belong, as defined in the Webster's New Collegiate Dictionary, is to be suitable, appropriate, or advantageous.

Although this research study's intent was to explore the experiences of mentally ill offenders and their service providers within the Health Care Centre of the Lower Mainland Regional Correctional Centre, the issue of whether this group belongs in this facility at all was raised by several of the participants of the study. In other words, is the correctional facility an advantageous, or suitable or an appropriate place for the mentally ill?
(i) mentally ill offenders

Consistent with the earlier findings, the mentally ill offenders who participated in this study were rather indifferent to the milieu they found themselves in. Their passivity can be in part attributed to the nature of their illness and their preference to be associated with the criminal subculture rather than with the stigma of being psychiatrically impaired. Furthermore, some felt that it was preferable to be serving a definite sentence instead of an indeterminate period of hospitalization. This is because detention in a hospital for some, was perceived to be arbitrary, a decision that is dependent on their progress or level of functioning. As one participant stated:

"I prefer Oakalla because you know when you're gonna get out".

(ii) correctional personnel

According to one of the participants, individuals with mental illnesses "do not belong" in a correctional setting as they present a risk to the staff members. This view is evidently further supported by one of his peer who made the following comment:

"These guys don't belong here, but they keep coming back!"
However, this sentiment was not shared by all. A community health care professional who participated in this study made the following observation:

"Every now and then you run into a guard who seems really tired and worn out, and seems to think that they really shouldn't be dealing with these people, and if only mental health would do their job, then they wouldn't have to. But most of these guys I've run into have pretty well resigned to the fact that they have these guys there that are mentally ill who are their responsibility and they just want to know more about it".

(iii) health care professionals

Most of the health care professionals who participated in this study accepted the fact that there is an increasing number of mentally ill individuals who are being housed in the correctional facility. The issue of whether this is advantageous, suitable or appropriate was not raised. For the most part, pragmatism prevails, albeit with some discomfort. This group tends to focus on providing the best possible care within the confines of the limited resource. However, the frustration of having mentally ill individuals in the correctional system was articulated by a senior health care professional who participated in this study. He states:

"Somehow, the system has broken down via the Criminal Code...if someone is arrested by the police or arresting personnel, either friends or family who suggest that something is wrong with them mentally, they're to have a psychiatric examination. They should go
before the court so that a judge can decide whether or not the person may be mentally ill and should be remanded for thirty days at a psychiatric facility like FPI. Well sometimes that process doesn't happen! And so, the patient who is mentally ill, probably not even competent to instruct counsel, has a duty counsel who doesn't even know them, ends up in the system, sort of crazy out of their mind. They go there to Oakalla. I'm sure a lot of cases are missed in the system. So the whole system, the whole Criminal Code, the whole thing doesn't work! And then, there are those who are remanded, in custody, who are mentally ill, awaiting for trial, same thing!...I don't think prison is a place for psychotic patients. And I think it's ridiculous that they are there. It's not fair to them, not fair to the staff. They should be treated in a hospital, an appropriate hospital, not prison....Most of them who are psychotic probably should be found Not Guilty By Reason of Insanity anyways. Or they should have a different kind of sentence, or should be diverted....Why they end up there, with lengthy sentences, being chronically ill, is a failure of the system. Part of the problem is that some of these people don't want to be found NGRI...Now, the new Criminal Code is gonna change that. You're gonna get a determinate sentence even if you're found NGRI...It would be different. It may pick up some of them. At least maybe some of the defence counsel will use it a bit more....But it's a philosophical thing, the major mental illnesses, as far as I'm concerned has no place in prison....But right now, what's even worse, FPI is jammed to the rafters. I have very sick patients. It's like a patient with an acute abdominal problem who cannot go to the hospital for surgery. I've got these patients who are psychotic, who hears voices, delusional, who are out of their minds, certified and sitting in Oakalla and I can't treat them 'cos I don't have a mental health facility. Some of them it's OK to treat them, but a lot of them can't give consent to treatment, and I've got nowhere to put them. So they stay there. It's criminal!...I need hospital beds!"
In summary then, the issue of whether the correctional facility is an advantageous, suitable, or appropriate place for the mentally ill was met with a variety of responses. The mentally ill group for the most part, was indifferent although they did voice some preference for the 'finite' nature of the correctional system. In view of the earlier findings, it is unlikely that this group feels that they belong anywhere. While some of the service providers who participated in this study passively accepted the existence of the mentally ill individuals in a correctional facility, their comments indicate that they accept them begrudgingly. Finally, some of the service providers, both correctional personnel and health care professionals, felt very strongly that the mentally ill do not belong in a correctional facility. Their reasons for this, however, differ. For some of the correctional personnel, the mentally ill evoke fear and frustrations, as illustrated in the previous findings. Like all of us, it is easier to reject what threatens us. With respect to the health care professionals, their convictions are founded on a set of philosophical beliefs. They can be summarized as follows:

1) the belief that individuals with mental illnesses should receive the best available medical treatment;

2) the belief that an individual who is not able to fully appreciate the nature of his or her act(s), or the omission of, as a result of a mental illness should receive treatment rather than punishment; and
3) the belief that individuals with mental illnesses should receive humane care.

**DISCUSSION**

The fact that each of the above mentioned beliefs are formally endorsed at a policy level either in the Criminal Code of Canada, or in the Deinstitutionalization policy of the Mental Health System, raises three important questions. They are:

1) Why is there a noticeable increase of arrest rates among the mentally ill population?;

2) Why are individuals with major mental illnesses sentenced to a correctional facility instead of a designated psychiatric facility where they can receive the necessary, suitable, and appropriate medical treatment?; and

3) Which system should be is responsible for this group?

To begin with, there are no specific formal documents regarding the change in arrest rates of mentally ill individuals available at this time. At least none that would meet the rigor of scientific research. Having said that, there is ample information in the literature, as reviewed in an earlier chapter, that discusses the phenomenon of the
criminalization of the mentally ill, suggesting that there is an increase in the number of mentally ill individuals who are in the criminal justice system. A possible inference one could draw from this observation is that psychiatrically impaired individuals are simply engaging in more criminal activities. However, a more compelling explanation is one that is supported by many experts in the field. That is, the increase in the arrest rates of mentally ill individuals is a direct result of a poorly implemented social policy, Deinstitutionalization. Furthermore, the provisions within our Criminal Code lend support to this criminalization process.

IMPLICATIONS OF THE FINDING ON THE INCONGRUENCIES BETWEEN STATED SOCIAL POLICIES AND ACTUAL PRACTICES

Whether one argues that the deinstitutionalization policy of psychiatric patients was founded on naive idealism or calculated fiscal pragmatism, the reality remains that there is a large body of ill-prepared psychiatric patients residing in the community. Many of these 'ex-patients' are unable to care for themselves, unable or unwilling to seek treatment, unable to access the necessary services and support, and are engaging in socially inappropriate behaviors more noticeably. The community is becoming increasingly intolerant of this group and is demanding police intervention. As Progrebin and Poole (1987) note: "Police departments have become the most utilized agencies for psychiatric referral in our society" (p.119).
Consistent with the Deinstitutionalization policy, admission to the local or provincial psychiatric facilities is often difficult, cumbersome, and time-consuming. Police officials are often discouraged by this process, especially when their judgements are disputed by psychiatric clinicians. (Borzecki and Wormith, 1985) Consequently, police officials' often feel their only recourse is to lay criminal charges and remove the mentally ill individuals from the community by placing them in the local jail. It is assumed that the 'system' in place would address the needs of the mentally ill individual. However, as Lang (1986) points out in her article The Folly of Fitness:

"Paradoxically, a doctrine which ostensibly exists for the protection of the mentally disordered accused often works to his disadvantage" (p.221).

The current provisions within the Criminal Code are also fraught with problems. For the purposes of this discussion, the focus will be on how it effects mentally ill individuals who are accused for committing non-capital offences. Basically, the 'indefinite' nature of the disposition if the accused is found not guilty by reason of insanity and/or unfit to stand trial is perceived to be excessive, arbitrary, and unfair. Widely publicized horror stories such as the 'purse snatcher' who was found Not Guilty By Reason Of Insanity and had been 'incarcerated' in the backwards of a psychiatric facility for twenty years, generate great reluctance on the
part of the accused to raise the issue of whether he or she was suffering from a mental disorder at the time of the offence so as to be exempt from criminal responsibility. Equal reluctance has probably been generated by the story of an individual charged with a breaking and entering offence, was found unfit to stand trial and was subsequently detained for three years before being returned to the court when it was determined that there was not sufficient admissible evidence to even place him on trial. Such stories serve to deter accused persons from raising the issue of whether they were suffering from a mental disorder. In brief, the fear that one could be detained for a period of time that far exceeds the stated maximum possible sentence encourages the mentally ill accused to avoid Section 16 of the Criminal Code even though it was designed to protect them from criminal responsibility. Instead, the mentally ill individual may prefer to be tried and found guilty and sentenced to a correctional facility.

There can be many disadvantages for the mentally ill individual who is diverted into the criminal justice system. The primary one is the lack of opportunity for access to the appropriate and necessary treatment. Also, the label 'mentally ill offender' weighs heavily against the individual, and access to mental health and social services becomes increasingly difficult. The mentally ill individual is then left all the more vulnerable, which in turn perpetuates the criminalization process.
Understandably, the juxtaposition of law and psychiatry has received much criticism - both in its philosophical and practical implications. Depending on one's philosophical beliefs, one could argue that all individuals who are psychiatrically impaired should not be processed through the criminal justice system. Instead, they should be hospitalized where they can receive medical treatment. Others could argue that all individuals who behave 'illegally' should be incarcerated and receive the same opportunities as all inmates regardless of their psychiatric impairment. Common sense tells us that the best solution can be found in the balance of the two extreme beliefs.

It would appear that a reasonable and responsible solution must include the protection of the public and the provision of treatment and humane care for the mentally ill. The debilitating effects of incarceration have been well documented. Incarceration without any real opportunity for skills development has no therapeutic value; but rather, it impedes the potential for successful community reintegration.

Part of the problem lies in the fact that civil libertarians and defence counsel frequently prefer a term of imprisonment on behalf of their clients rather than demanding responsible and appropriate treatment for their mentally ill clients. When one examines the experiences of mentally ill
offenders - which include the revolving door syndrome, trans-institutionalization, homelessness, and psychosocial impoverishment - it is evident that this group is not receiving the treatment and support that meet their needs. Individuals with mental illnesses should have a right to treatment. Without such treatment they will remain disconnected and alienated.

We can all be part of the solution. A responsible, humane, and ethical society requires that we assume personal responsibility as well as demand a collective responsibility and accountability. After all, the most important sign of civility is how a society treats its marginal members.

**SUMMARY AND CONCLUDING COMMENT**

This paper began by presenting a brief review of the history of the North American mental health system that led to the current community mental health movement and its Deinstitutionalization policy. For many of our mentally ill patients, deinstitutionalization meant the additional burden of coping with socio-economical impoverishment and the lack of asylum. The criminalization of the mentally ill has been identified as a distinct problem that is worthy of recognition.

A study was undertaken by the researcher to look at the experiences of mentally ill offenders and their service
providers. It was motivated by the interest to identify service and program needs for this specific group within a correctional setting. It was determined that a qualitative research design would be most appropriate to achieve this goal.

Three primary themes emerged from the findings. They are: alienation, lack of organizational commitment, and the incongruencies between the stated social policies and actual practices. Efforts were made by the researcher to understand the origins of these three themes and analysis of them led the researcher to conclude that the problems are inter-dependent.

Although some concrete alternatives were presented, the hesitancy to make specific program recommendations stems from the fear that the central issue may get lost in the process. Information on programs that are sensitive to the varying needs of the mentally ill are readily available. It is not necessary to re-invent the wheel.

During the past few years, a number of individuals within our local agencies and organizations have worked in collaboration with each other to develop specific programs for mentally ill offenders - both in the community and in the various institutions. (See Appendix G) In addition, distinct efforts are being made in the reform of the Provincial Mental Health Services, the B.C. Mental Health Act, and the Criminal
All in response to the identified problems experienced by the chronic mentally ill population. While these initiatives appear encouraging, the effect of these programs and the anticipated policy changes would be highly dependent on the actual commitment of our policy makers. Individual excellence can only endure if there is explicit political will and active organizational support.

Of utmost importance, really, is that in our pursuit for solutions, we are not seduced by 'quick fixes'. It would appear that what is lacking is a common vision. A vision that is based on the fundamental values of human dignity, mutual respect, and active partnership. A vision that would give society the courage to put an end to the abandonment of our mentally ill. Very obviously, a vision without action is nothing more than an academic exercise. What is required is for policy makers and service providers to engage in continuous, open and vigilant consultative processes to strengthen collaborative efforts. In conjunction, concrete actions with a critical evaluative component must be undertaken. After all, we are all responsible.
For example, see Hobbs, (1964); Foucault, (1965); Scull, (1977); and Grob, (1983).


Ibid.

An exploratory study was conducted by the researcher as part of a course requirement of the Social Work 551 in the Spring of 1989. As a result of this study, one of the recommendations in the student paper was to include non-incarcerated mentally ill offenders, and service providers who are not employed at the said facility. "This would bring in relevant data that would either confirm the identified themes and/or allow the emergence of different realities from the perspectives of other key actors. In particular, is the retrospective data of non-incarcerated mentally ill offenders, and how their past experiences of incarceration impact on their current experiences, and what they perceive as perhaps beneficial now. The inclusion of a varied sample distribution would provide a richer perspective for the understanding of the service needs for mentally ill offenders" (p.48).

Axis I of the DSM-III-R consists of major mental illnesses such as schizophrenia, affective disorders, organic brain syndromes, etc. Axis II of the DSM-III-R consists of personality disorders such as antisocial, borderline, schizoid, histrionic, passive aggressive, etc.
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APPENDIX A

YOUNG ADULT CHRONIC PATIENTS

The Young Adult Chronic Patient Population has been identified as individuals between 18 and 35 who have "spent relatively little time in hospitals but who present persistent and frustrating problems to community caregivers...who are psychiatrically and socially impaired, so seriously that they are continually or recurrently clients of mental health and other social service agencies over a period of years" (Lamb, 1981, p. 463). This group carries a variety of labels: schizophrenia, affective disorder, behavior disorder, personality disorder, substance abuser, attention deficit disorder, mental retardation, learning disability, organic brain syndrome, etc. Regardless of their clinical differences, the one main commonality that this group shares is that "from the onset of their illness...[they]...have been treated during the era of deinstitutionalization" (Caton, 1981, p. 475). This group is socially isolated, transient, homeless, disengaged, impulsive, victimized, and perpetrators of crime. They are characterized by "assaultive behavior, severe overt psychopathology, lack of internal controls, reluctance to take psychotropic medications, problems with drugs and alcohol in addition to their psychoses and in some cases self destructive behavior" (Lamb, 1982, pp. 466-467). According to Finlayson et
al (1984) this group are "involved in initial police occurrences four times more often than the general population, additionally, most had multiple reported contacts with police" (p.638). For the young adult chronic patient, admission to mental illness is admission to failure. Consequently, this group self medicates and becomes involved with the criminal subculture. Criminals, at least, are competent enough to commit a crime. They are unlucky because they get caught. Whereas, being a mental patient is a clear indication of incompetence.
APPENDIX B
INTERVIEW GUIDE

I: Inmate/Patient
Nature of Offence

Diagnosis Given and One's Understanding of Such
Duration of Stay
Experience with the Criminal Justice System
Other Hospitalizations and/or Institutionalizations
Community Involvement with Agencies
Expectations
Experiences
Type of Care Currently Receiving
Type of Care Received Elsewhere
Type of Care that is Desired
What would be most useful for optimizing the current stay?
What would be most useful while out in community?
Types of Concerns while Incarcerated
Types of Concerns while in the Community

II: Staff
Length of Employment
Experience with the Mentally Ill Offender
Impact on one's role, and relationship with other colleagues
What would be most useful for one as a service provider?
What would be most useful for the mentally ill offenders?
Types of Concerns in working with the Mentally Ill Offender
What are the strengths and limitations of the current system?
Your signature below on this page indicates that you have received a copy of the consent form that explains the purpose and procedures of the study titled, Services for Mentally Ill Offender: An Exploratory Study. It also indicates your voluntary agreement to participate in this research study. If you would like to receive a free summary of the results of this study when it is available (likely Spring 1990) please also print your mailing address in the space provided.

I understand that I am under no obligation to complete this consent form. No decisions regarding my stay in the Health Care Centre of Lower Mainland Regional Correctional Centre would be influenced by my decision to participate or not participate in this research study. My involvement will be used for research purposes only. My rights to privacy and confidentiality will be fully respected. I have the right to decline to participate in this research study. I have the right to withdraw from the research at any time. I understand that I do not have to be tape recorded during the interview(s) if I do not choose to. I know that the length and number of interviews will be dependent on me.

I have read and understood the purpose and procedure of this research study. I understand that the information gathered will be used to assist the co-investigator, Lily, in identifying the service needs of mentally ill offenders. I have read the above statement of my rights and voluntary consent to participate in the research study by completing the following:

Signature.................................................................

Name (Please Print)......................................................

Address.................................................................

City, Province...........................................................

Postal Code.............................................................
Your signature below on this page indicates that you have received a copy of the consent form that explains the purpose and procedures of the study titled, Services for Mentally Ill Offender: An Exploratory Study. It also indicates your voluntary agreement to participate in this research study. If you would like to receive a free summary of the results of this study when it is available (likely Spring 1990) please also print your mailing address in the space provided.

I understand that I am under no obligation to complete this consent form. No decisions regarding my employment in the Health Care Centre of Lower Mainland Regional Correctional Centre would be influenced by my decision to participate or not participate in this research study. My involvement will be used for research purposes only. My rights to privacy and confidentiality will be fully respected. I have the right to decline to participate in this research study. I have the right to withdraw from the research at any time. I understand that I do not have to be tape recorded during the interview(s) if I do not choose to. I know that the length and number of interviews will be dependent on me.

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Signature..........................................................

Name (Please Print).............................................

Address..........................................................

City, Province..................................................

Postal Code.....................................................
APPENDIX E
DATA ANALYSIS

The plan for data analysis is seen as consistent with qualitative methodology. In the process of gathering data, one constantly looks for patterns, themes, or organizing constructs which, as they emerge, form a tentative analytic framework. This framework may involve the construction of categories or hypotheses which, in turn, guide, and are further modified by, the ongoing collection of data. This process of sequential analysis and increasingly focused data collection continues until a satisfactory grasp of the phenomenon is achieved. At this point the accumulated data is subjected to a final period of systematic reflection, analysis, and interpretation. This form of qualitative analysis is a system of concurrent collection and analysis of data, with these two processes sequentially influencing and modifying each other.

The specific analysis used was the constant comparative method (C.C.M.) described by Glaser and Strauss (1967). Their methodology stresses that this joint/sequential process of collection, coding and analysis is essential to the generation of systematic theory - theory which is truly grounded in the obtained data. A constant comparison of both similarities and differences is made. Thus, the researcher is continually assessing the degree of fit, or incompatibility, as the data is
assigned to various categories. The degree of fit between and within categories is assessed in order to begin to sense the significant groupings and their potential relationships. These form the basis of themes and, eventually, of the generation of theory which is the objective of this research.

The Constant Comparative Method system of Glaser and Strauss is a method which stresses the sequential process of collection, coding, and analysis of data; where this data is obtained from a line-by-line coding of the researcher's field notes. To elaborate, the C.C.M. procedure has been employed primarily with participant observation studies in which the obtained data take the form of the concise summarizations from an observer's field notes. These summarizations became the primary unit of analysis and were then coded using Glasser and Strauss's open-coding:

...the goal of the analyst is to generate an emergent set of categories and their properties which fit, work, and are relevant for integrating into a theory. To achieve this goal, the analyst begins...[by]...coding the data in every way possible...[he]...codes for as many categories that might fit; he codes different incidents into as many categories as possible.

During the coding process the analyst sought to continually compare both the similarities and the differences between these units of analysis as they were being assigned to categories.
This provides an ongoing assessment of the degree of fit of each piece of data as it is being considered for a particular category. Such an assignment/analysis process generates the reflections and interpretations (memos) which in turn provide the organizational constructs and tentative analytic framework from which the basic themes and theory generation will emerge. This process is essential to the emergence of theory which is truly grounded in the data, and thus remains consistent with the principles of C.C.M.
APPENDIX G

INITIATIVES AND A LOOK TO THE FUTURE

As a consequence of the community mental health movement, there has been a significant increase in the number of psychiatric patients in the community. Within British Columbia, mental health professionals believe that the deinstitutionalization policy with its strict hospital admission criteria and the patient rights movement have contributed to an increase of mentally ill individuals being processed through the criminal justice system. This conclusion has been echoed in the literature on mentally ill individuals in the community. In the following, I will identify some of the local agencies and organizational efforts that have been and are being made in direct response to this problem. In addition, distinct efforts in the reform of the Provincial Mental Health Services, the reform of the B.C. Mental Health Act, and the amendments of the Criminal Code of Canada to respond to this problem will be presented. What becomes apparent is that the individual commitments are there already, and the future of the mentally ill can be quite encouraging if there is political and organizational will to act and lend support to individual efforts.

In 1984, a group of representatives from different B.C. provincial government ministries and local private agencies met
to discuss the management problems of multi-problem mentally ill individuals. (Buckley et al., 1991) It was agreed that the deinstitutionalization policy had contributed to the criminalization of the mentally ill. It was apparent to all participants that a group of multi-problem mentally ill individuals were being cycled through various services such as hospitals, mental health centres, alcohol and drug treatment programs, forensic psychiatric services, correctional institutions, community corrections, and other private agencies.

In 1985, following a series of inter-agencies meetings, an agreement was reached to jointly establish a service coordination program specifically for the service providers of multi-problem mentally ill individuals. (Buckley et al., 1991) Part of the mandate of this program is also to develop a data base of information on this group and to identify the gaps in the system. Of significance is the fact that this program is the first collaborative effort undertaken locally to address the problems of mentally ill individuals who are being cycled through our various systems of care.

Also in 1985, a consultative process was initiated by the Mental Health Services Division of the Ministry of Health. The purpose was to review the province's strategy for the provision of mental health services. Participation from interest groups and individuals was relatively widespread.
In 1987, the Mental Health Consultation Report, based on the consultative process, was completed. It was viewed as the blueprint for the future of the B.C. mental health system. Reform of the provincial Mental Health Act was also anticipated.

In 1987, the Forensic Psychiatric Services, the B.C. Corrections Branch, and the Greater Vancouver Mental Health Services Society, (three of the six sponsoring agencies from the above mentioned program) implemented a community-based assertive case management program specifically for multi-problem mentally ill individuals. The initial mandates were simple. They were:

1) to encourage multi-agency collaboration;
2) to engage multi-problem mentally ill individuals; and
3) to improve their quality of life.

What was unique about this program was that there were no budgets allocated, and consequently everyone begged and stole and shared what little resources they had including pens and paper. This program has effectively achieved its primary mandate in that the senior managements of these three agencies have continued to work collaboratively in all areas of the services. More importantly, the 'clients' of this program are no longer lost to the system.
In 1988, Riverview Hospital piloted two assertive outreach research programs for mentally ill individuals who were discharged into the Greater Vancouver Area as well as into the Fraser Valley Area. The Greater Vancouver Area program was met with a great deal of resistance, and was ultimately disbanded. It seems most likely that this result was due to the lack of consultation and collaborative efforts with the other agencies. Although the mandates of the program were similar to the assertive case management program referred to previously, the research component overwhelmed the service component and the 'clients' remained underserved. A lesson to be learned here is that the lack of commitment to consult and to work collaboratively together was met with failure regardless of the stated mandates.

In the summer of 1990, the Assistant Deputy Minister's Committee on Deinstitutionalization invited representatives from Mental Health Services, Forensic Psychiatric Services, Social Services and Housing, Alcohol and Drug Programs, Corrections Branch, Criminal Justice Branch, and the Vancouver Police Department to participate in a subcommittee that would review the effects of multi-problem persons on the Criminal Justice System. The terms of reference given were to:

1) review the management and treatment problems;
2) monitor current issues related to the management of mentally disordered multi-problem persons;
3) review relevant provincial and federal legislation;
4) monitor the impact of deinstitutionalization on the criminal justice system; and
5) suggest strategies to improve treatment and the coordination of treatment services.

It was agreed that the establishment of province-wide interministerial guidelines (completed by November of the same year), would be an appropriate policy response. The protocols were viewed as the first step in the process of improving cooperation between various agencies who share responsibility for this group. Of significance here is the following comment:

"Governments which have the responsibility of ensuring the protection of the general public also have the moral and ethical responsibility to prevent prisons from becoming the repository for multi-problem mentally ill persons. One response to this growing social problem in British Columbia is government policy-making which stresses increasing interministerial cooperation in service delivery in order to develop strategies that provide appropriate comprehensive assistance to mentally disordered offenders. The actions of government are not always viewed in a favourable light, but here is an example where government intervention may have a beneficial effect on an unfortunate and deserving group in society caught up in a previously unsympathetic process" (Hightower and Eaves, 1991, p.7).

In 1990, the Mental Health Initiative was approved by the Provincial Cabinet. The Initiative was based on the philosophy that:
1) treatment and rehabilitation should be provided in settings that are most appropriate to the needs of the individual; and

2) services should work to facilitate the community re-integration process.

In addition, a set of principles were adopted. They are: comprehensiveness, coordination, continuity of care, availability and accessibility, and accountability. More importantly, the then Health Minister John Jansen announced that the "provincial government is committed to improving the existing mental health care system in British Columbia" (February 26th, 1990; press release). Moreover, Jansen said that the B.C. Mental Health Initiative was:

"a model of participatory policy development producing a world-class vision for the care of the mentally ill. The government is dedicated to continuing partnerships as we work together to realize our commitment to the mentally ill" (Ibid).

Also in 1990, several local community-based programs were established to provide services for multi-problem mentally ill individuals. For example, the St. James Social Services and Lookout Emergency Services Case Management Projects, and the Mental Patient Society Courtworker Program added a case management component. The newly established Fraser Valley Regional Correctional Centre has a community-based case management program for their mentally ill inmates. Similar plans are in the making for the Vancouver Pre-trial Centre, the
Surrey Correctional Centre, and the Regional Correctional Centre for Women. The planning process includes consultation and collaborative efforts between the local mental health centres, B.C. Corrections, and Forensic Psychiatric Services. In addition, it should be noted that several months ago the Vancouver Pre-trial Centre initiated staff training in the area of mental illness as well as an occupational therapy program for psychiatrically impaired remanded individuals.

Currently various mental health agencies have been invited by the Ministry of Health to review and submit recommendations for the reform of the Provincial Mental Health Act. The submission deadline is June, 1991. It is anticipated that the reform of the B.C. Mental Health Act will become a reality in the near future. Some of the recommendations put forward by the Forensic Psychiatric Services appear to be quite encouraging. For example:

"That the Act should be patient-centred... should meet the guarantees provided by the Charter of Rights and Freedoms...that it should reflect a 'need for treatment model'...an acute or emergency situation,[should] be met with a minimum of administrative interference...recognition [should include the] patient's rights to receive information regarding treatment" (Forensic Psychiatric Services, 1991).

Furthermore, with respect to the issue of the criminalization of the mentally ill, the following comments were made:
"At present, too often we see that appropriate psychiatric care is not forthcoming...Individuals are left untreated until their illness results in actions that compel the intervention of the criminal justice system...We are concerned that a 'pure detention model' of mental health statute will aggravate rather than alleviate this problem...patients falling within the admission criteria should be given priority". (Ibid)

As well,

"It is the Committee's view that the duty of mental health services continues past an individual's release...there is the further need to provide for his or her re-integration back into the community. The new Act should acknowledge the significance of this duty by providing adequate time for discharge planning to meet the continuing needs of the patient". (Ibid)

Finally,

"Some form of administrative review is necessary, but should be keyed to the protection of and respect for patient's rights and to a recognition that individuals suffering a mental disorder are often amongst the most vulnerable members of society. Indeed, these person's very vulnerability raises the legal standard of care required of medical and clinical staff. These factors must be foremost in ensuring substantive fairness and conscientious conduct in the clinical decision-making process enshrined in mental health legislation". (Ibid)

During the past five years, the Federal Government has circulated a number of proposals to reform the criminal law in
relation to the defense of insanity and the options for the 
control and treatment of persons found not guilty by reason of 
insanity. The House of Commons of Canada is currently 
considering a sixteenth draft of the proposed amendments. 
Providing that these recommendations are accepted, a revised 
Criminal Code would address such issues as:

1) maximum duration of disposition made following a 
verdict of Not Guilty By Reason of Insanity;
2) what to do where a prima facie case for committal for 
trial cannot be made;
3) appeal process following a disposition in respect of 
insanity;
4) duties and powers of the Review Board for persons 
deemed Unfit To Stand Trial or Not Guilty By Reason of 
Insanity; and
5) burden of proof in cases where criminal insanity is 
raised.

On May 2nd of this year (1991), the Supreme Court of Canada 
handed down a decision on the case of Owen Swain. (See Swain 
verses Regina) Basically, the Court had struck down s. 614(2) 
of the Criminal Code, which provided automatic strict custody 
for individuals found Not Guilty By Reason of Insanity. It 
ruled that s. 614(2) violated section seven (the principles of 
fundamental justice) and nine (the right not to be arbitrarily 
detained) of the Charter of Rights and Freedoms. A six month
'transitional period' has been granted to the Federal Government to enable enactment of new legislation that would meet the requirements of the Charter. This decision should certainly facilitate or "fast-track" the complete amendment of the Criminal Code. At a minimum, the amendments reflecting the Swain judgement will likely be presented for Parliamentary approval within the next six months.

The anticipated consequences of the proposed amendments will include three new kinds of psychiatric assessments. They are:

1) assessment to determine appropriate disposition;
2) assessment to determine the person's mental state at the time of the offence; and
3) assessment to determine if a hospital order is appropriate.

In most cases, particularly for the NGRI's continued incarceration, a determination must be made by the Lieutenant Governor in Council within thirty days. Finally, as the proposed amendments include procedural safeguards such as maximum duration of the disposition, the need for a prima facie case to be made, and continuing review, it is also anticipated that the mentally ill accused would raise the issue so as to be exempt from criminal responsibility more readily. The end result would be of course, that more mentally ill individuals would receive the necessary psychiatric treatment in an
appropriate facility that is sensitive to their needs, and where the protection of their rights is guaranteed, rather than their being an additional burden on an ill-prepared correctional facility.

Assuming that the Provincial Mental Health Services Branch is committed to the provision of quality care, active consultation and collaboration, and programs are designed to meet the five stated principles, what we would see then is a decrease of mentally ill individuals being deposited into the criminal justice system or being recycled through the various resources with no place to go.