

The changing landscape of treatment in forensic psychiatry

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Two years ago at this very conference...

- A presentation entitled : “The Changing Landscape of the Forensic System in Ontario” (Higgins, Weisberg and Gug, 2013) outlined a very important development;
- The concept of a “Transitional Case Management Program”;
- The goal being to “ facilitate and support the successful transition to the community of eligible persons in secure forensic beds with an ORB disposition that allows for community placement”.

A very important bit of information...

- “A unique system dynamic that is very different from virtually all other health care delivery in the province” (Higgins, Weisberg and Gug, 2013)...was used to describe the context of health care
- ...the *landscape*:

Forensic psychiatry in Ontario

- History of legislation and significant criminal cases in Canada
- NCRMD in the 1990's
- Stats # patients across decades
- Inpatient Tx
- Outpatient Tx
- Complexity today

Background history

- McNaughton Rules (1843) in Great Britain indicated that for an individual to be found Not Responsible for their act or omission, their mental disorder must render them unable to know the nature and quality of the act or that it was wrong.
- Influenced early Canadian practices

History (continued)

- Canada's first Criminal Code of 1892(6) made the "insanity defence" available to an accused person who, because of a "natural imbecility" or "disease of the mind," was incapable of appreciating the nature and quality of the act or omission, and of knowing it was wrong.

Insanity defense: early attempts in Canada (Bouget and Chaimowitz, (2010))

- In 1885, Louis Riel declared to be insane by Dr. Daniel Clark
- In 1895, Valentine Shortis charged with a double murder in Valleyfield Quebec (Defense was unsuccessful)

Lieutenant governor's warrants

- Used in Great Britain as enunciated by Criminal Lunatics Act of 1800
- Individuals adduced to be “dangerously insane” were detained in asylums at His/Her Majesty’s pleasure until sanity was restored (Treatment???)
- In the province of Canada (before Confederation) Governor-General’s warrants authorized removal of lunatics from jail to asylums

L.-G. Warrants (continued)

- Authorized by the *“1851 Act authorizing the confinement of lunatics considered to be dangerous to the public while at large” (aka/ “Criminal lunatics act”) at the pleasure of the Lieutenant-Governor (Belton, 1996)*

L.-G. warrants (continued)

- By 1887, under the “Act respecting the removal of persons from County Gaols to Provincial Institutions”, a separate warrant was required to authorize transfer of the “lunatic” from the jail to the asylum
- The entire process was then broken down into *committal, removal and transfer* components eventually resulting in the formalization of “admission”.

L.-G. warrants

- This practice continued until 1991 when R. vs. Swain was heard
- Decision resulted in the creation of the Ontario Review Board system as we know it today;
- Intent to treat fairly individuals just Not Criminally Responsible by reason of a Mental Disorder (NCRMD)
- “least onerous and least restrictive to the accused”

Other important developments

- Development of major tranquilizers
- Behavioural approaches to treatment
- Structured risk assessment
- Cognitive behaviour therapy
- Development of selective serotonin re-uptake inhibitors
- Dialectical behaviour therapy
- Winko, Pinet, Conway decisions (Lefrancois, Menzies and Rheaume, 2013)

Context: the future is here

- Client base has changed (TCM caseload)
- Legislation has changed (Bill C-14)
- New forms of violence are officially recognized (harassment, internet crimes, terrorism)
- Community has changed (multiculturalism on the rise)
- Diagnosis has changed (DSM-V)
- Recovery movement: Patients are active participants in treatment
- Major efforts to eliminate stigma

Cultural context has changed

- No chronic institutions (in name at least)
- Treatment occurs in the community-at-large
- Increased coverage in media
- Dramatization on TV and in movies
- Criminalization of SMI (Chaimowitz, 2012)
- “Pathologizing” of criminal behaviour

Code Red report

- “Ontario ranks at the bottom of the country in public hospital funding per person, neck and neck with Quebec” (Ontario Health Coalition, 2015)
- Cutbacks, closures systemic changes...

Institutional closures 1): psychiatric facilities

- In 1999 the Harris government proposed the closure of 29 different facilities
- Pundits with conservative leanings point out that this did not happen
- However, as of June 2014, 12 of these were in fact, amalgamated, downsized, closed or turned into clinics or retirement facilities

Institutional closures: 2) developmental services

- MCSS: Rideau Regional and Huronia Regional centres closed 2009: last of the chronic institutions for persons with intellectual disabilities;
- In most cases where a person with ID commits a crime, they are deemed permanently unfit to stand trial: where do they go?

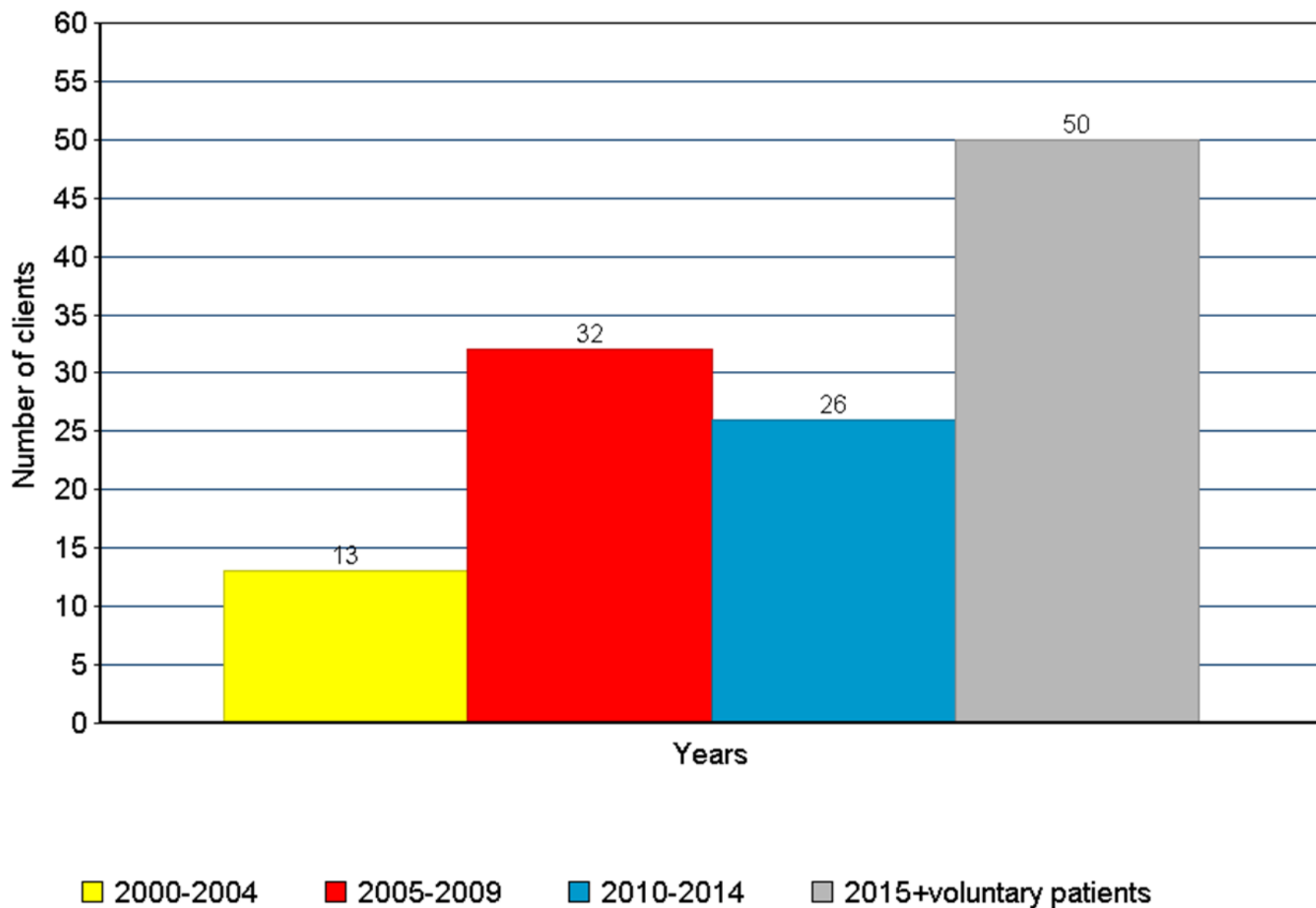
Institutional closures 3): correctional facilities

- Closures over the past 5 years:
- Toronto (X2), Kingston (X2), Owen Sound, Walkerton, Sarnia, Mimico, Brantford, Chatham....

Community Treatment: influences

- Closure of jails, hospitals, institutions
- MOHLTC ALC management
- Recovery movement
- Net affect on clientele is to place more patients into the community
- Our (Brockville) data over time:

Forensic Clients in Community Housing



Criminalization of SMI

- Chaimowitz (2012) on Penrose effect: there is an inverse relation between the number of inmates in prisons and the number of patients in hospitals.

“Pathologizing” of criminal behaviour

- Media- Dramatization on TV and in movies:
- TV- CSI, Criminal Minds, Dexter; Hannibal gets his own series!
- “COPS”
- “Forensic files”
- Convenient stories of troubled childhoods leading to anti-social behaviour
- (more on this later...)

Changes in diagnostic practices (DSM-V)

- Prior to the adoption of the new DSM there was considerable debate on how to best conceptualize anti-social behaviour for therapeutic purposes;
- Even if the new conceptualization proves to be more practical in this respect, there will still be a “learning curve” phenomenon to deal with

Bill C-14

- The bill amends the statutory framework that deals with mental disorders in the Criminal Code (Code)² (Part XX.1) and the National Defence Act.³ According to its summary, the bill's objectives are these:

Bill C-14 (continued)

- to specify that the “paramount consideration” in the decision-making process is the safety of the public (clause 9);
- to create a scheme for finding that certain persons who have been found not criminally responsible on account of mental disorder are also “high-risk accused” (clause 12); and
- to enhance “the involvement of victims” in the processes concerning mental disorder (clauses 7 and 10).

Ashley Smith inquiry

Attention drawn to:

- Treatment of offenders with mental illness
- Management of care in facilities dealing with clients with correctional and mental health needs
- Review, oversight and support mechanisms for segregated offenders and those engaging in self-injurious behaviour

Our own experience

- RAI data: most complex forensic patients in the province
- F.I.T.T.: 4 outpatients with over 100 years institutionalization with Criminal and psychiatric histories
- In-patient treatment experience of CSC high-need female offenders

The future is now

- Complex patients cared for in the community
- Risk management is the key
- Psychopathology and criminal behaviour occur in a social context
- This suggests a need for a high degree of structure, organization of the care environment

Farrington Theory

- Based on interpretation of data culled from the Cambridge Study (Farrington, 2003)
- Followed 411 South London boys from the age of 8 to 48
- Concluded that stability in criminal behaviour resides in the individual rather than the environment
- The basis for early intervention programs

Farrington Theory: criticism

- Medicalizes the social problem of crime, constituting a psychological model of anti-social behaviour rather than a theory of crime and delinquency
- Risk management approaches derived from such an approach fail to address the dynamic nature of criminal behaviour
- Simplifies the complex social processes that promote or inhibit delinquent behaviour over the life course (Buffone, 2012)

Travis Hirschi's Control theory

- “When an individual's bonds to society are weakened or absent, the propensity to engage in anti-social behaviour and crime increases” (Hirschi, 1969).



Social Strain theory

- Society has a dominant set of values and goals;
- There are acceptable means of achieving the goals;
- Some people are unable to access these means;
- This creates social strain (Merton, 1938).

Strain theory...



Treatment contextualized (continued)

- As our client population becomes more complex and consequently more of a challenge to manage...
- We attempt to do so in institutional and community settings that are no longer isolated (i.e. an “asylum”), thereby subjecting our clients to the manifestations of social “strain” such as stigma, poverty, labour unrest, violence in media;

Treatment environments

- Because of the impact of “social strain” we must invest extra effort in engineering treatment environments that:

What therapeutic environments do:

- Teach effective management of social strain;
- Manage and control risk, triggers, destabilizers;
- Model, support and encourage cooperative prosocial behaviour;
- Place patient safety concerns above all others;
- Anticipate impediments to therapeutic effectiveness;



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