The Advisory Review Board and Characteristics of Patients on Warrants of the Lieutenant Governor in Ontario

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In recent years, much attention has been focused on the mentally ill offender, particularly those found "not guilty by reason of insanity" and "unfit to stand trial." The more recent trial and verdict involving John Hinckley, Jr., in the United States, has given momentum to the desire on the part of some to completely change the system. In Canada, the 1976 report of the Law Reform Commission on *Mental Disorder in the Criminal Process*[1] is still regarded by some as the blueprint for change.

This article is an analysis of the Ontario Advisory Review Board and a description of persons held on warrants of the Lieutenant Governor in that province.

The *Criminal Code of Canada*,[2] specifically Section 16, defines the criteria for mentally ill individuals who came into contact with the law. While the *Criminal Code* defines the law in terms of the mentally ill offender, it also permits the provinces of the country to develop specific laws and regulations under provincial jurisdiction. This is usually done under the appropriate provincial mental health legislation. The system in Ontario is one of the oldest and has the largest number of cases on warrants of the Lieutenant Governor in Canada (LGW).

Under legislative guidelines provided in the *Criminal Code* and developed by this individual province, an Advisory Board of Review, consisting (in Ontario) of a supreme court judge as chairman, two psychiatrists, a member of the provincial bar, and a layman, is appointed to review each person held under a warrant of the Lieutenant Governor anually, sometimes more often, and to make recommendations to the Lieutenant Governor-in-Council, with regard to each individual. The Lieutenant Governor or Lieutenant Governor-in-Council (cabinet) may or may not accept the recommendations of the Board. The Board reviews each individual using the following criteria: (1) *fitness*: Is he now fit? That is, has he recovered from his mental illness enough to stand trial?; (2) *dangerousness*: Is he a danger to himself or to society?; and (3) *public interest*: Is it in the interest of the public to release the individual?

Persons held under these warrants are rarely released from the maximum

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security hospital into the community. Instead, they are placed on a loosened warrant and sent to a medium- or no-security regional psychiatric hospital. There, they may be gradually allowed into the community before the warrant is completely vacated.

There is much criticism of this system, some on legal, some on clinical, and yet others on social grounds.[3-6] Briefly, some of these criticisms are as follows.

It has been argued that Section 543(6) of the *Criminal Code of Canada* (1982), requiring a judge to order automatic and mandatory commitment of a person found unfit on account of insanity to stand trial, is in violation of the *Canadian Charter of Rights* (1982). It is also contended that indefinite detention and indefinite remand of an individual found unfit to stand trial under conditions more harsh than those of involuntary loss of liberty under a civil commitment order is cruel and unusual punishment. The role of the Advisory Review Board and the criteria for reviewing individuals under warrants is a subject of ongoing discussion. Although the hospital and the psychiatrists in Canada hold the rehabilitation of their patients as a priority objective in their actions, the Advisory Review Board must, from a practical point of view, give priority to the interests of the public. Some have argued that the Boards should be turned into courts and be forced to adhere to rigid procedures and that psychiatrists, both those on the Boards and those from the psychiatric hospitals, should have to face cross-examination and thus be forced to defend their views.

Mental illness, in the minds of the public and a large number of professionals, has always been erroneously associated with dangerousness. Greenland[7] has noted that the failure of psychiatry and the law to deal satisfactorily with the issue of dangerousness does not mean that this complex issue will be neatly resolved by the magic of social policy analysis. This implies that the redefinition of dangerousness, the specification of appropriate protective measures, and the assessment of community tolerance are matters of public concern and not the monopoly of anyone with professional wisdom.

In a study of the characteristics and dangerousness of patients held on warrants of the Lieutenant Governor, Quinsey[8] noted that, as a group, patients on warrants are either less dangerous than other patients held in security hospitals or are about as dangerous as those other patients, but certainly not more dangerous. They further observe that there are no data which indicate that patients on warrants are either more or less dangerous than persons who have committed similar crimes and are serving fixed sentences in correctional institutions. Therefore, they conclude that a special review policy for these patients, which involved the institution review board, cabinet, and the Lieutenant Governor and that removed the power of

release from the hospital, cannot be justified on the grounds that the patients on LGWs are more dangerous than those handled by simpler procedures.

The problem in part, as articulated by Greenland,[9] points to the following:

1. Sensationalization of incidents involving mentally ill offenders generates increasing levels of fear, irrational prejudices, and, in some cases, inappropriate community reaction.

2. Responses by politicians, governments, and community leaders to such overstated reporting affects the care rendered to mentally ill persons who are currently in the system.

3. Reaction on the part of the public challenges the credibility of the psychiatric experts, which in turn produces an increase in the demands for more punitive and custodial treatment of the mentally ill offender rather than the maintenance of the humane environment that is needed.

The Ontario Advisory Review Board

Prior to the establishment of the Ontario Advisory Review Board (ARB) in 1967, the sole means of review of the status of Ontario LGWs was a direct application to the Lieutenant Governor. The Ontario ARB was not created pursuant to Section 547 of the *Criminal Code.* Therefore, it is not a federal tribunal but a provincial statutory tribunal created by the Ontario *Mental Health Act.*[10]

The creation of the ARB as a provincial tribunal has resulted in minor modifications of the structure of the Board. Under Section 34(2) of the Ontario *Mental Health Act* (1980), the chairman of the Board must be a supreme court judge or a retired supreme court judge. Section 34 further adopts for the ARB, the provisions of Section 30(2) which govern the composition of regional review boards.

> Section 30(2) A review board shall be composed of three or five members at least one and not more than two of whom are psychiatrists and at least one and not more than two of whom are barristers and solicitors and at least one of whom is not a psychiatrist or a barrister and solicitor.

Four members of the ARB constitute a majority vote. If the Ontario ARB had been created pursuant to the *Criminal Code,* a quorum of three members would suffice.

The *Code* requires the ARB to review the case of persons in custody within six months of the original LGW and once annually thereafter. Under the Ontario *Mental Health Act,* Section 34, the ARB is simply required to review the status of LGWs once annually. Their practice, nevertheless, follows the *Code* provisions of initially at six months and annually. The *Code* requires the ARB to review the cases of any LGWs in "custody," which would include custody in a psychiatric facility or a prison. However,

the jurisdiction of the Ontario *Mental Health Act*, which created the Ontario ARB, only extends to LGWs identified with a psychiatric facility.

The review powers of the Ontario ARB have been expanded by the *Mental Health Act* which provides for a review upon the written request of the provincial Minister of Health. The Ontario ARB is further given discretion to transmit a copy of its recommendations to persons other than the Lieutenant Governor or Lieutenant Governor-in-Council. However, the review power itself is not discretionary; it clearly must be exercised.

Rights and Obligations of the Advisory Review Board

The procedural obligations relevant to the Advisory Review Board are defined in Section 30 of the *Mental Health Act* (1980), which sets out the procedures for regional review boards. Although a hearing need not be held, the practice in Ontario is to hold hearings in all cases. The patient's attendance is at the discretion of the chairman, as is the attendance of his counsel unless the patient does not attend. In practice, all patients currently detained in the province have their cases reviewed and are seen by the Board unless absent without leave. However, it is very rare for a patient not to attend the hearing. Section 32(3) of the *Mental Health Act* gives the patient the right to call witnesses and make submissions. There is generally no right of cross-examination by the patient's lawyer, although cross-examination may be allowed with the permission of the chairman. Section 32(4) directs the officer-in-charge to furnish the chairman with information and reports relevant to the inquiry upon the request. Section 32(5) permits the Advisory Review Board to interview a patient or any other person in private.

Since the procedures of the Advisory Review Board are not clearly defined by provincial mental health legislation or the *Criminal Code*, the Board has adopted its own procedures. The Honorable Mr. Haines, chairman of the Ontario ARB, has described the procedure as the "conference method."[11] Prior to the hearing, the two Board psychiatrists examine the patient, review his entire medical record, and all other information regarding the patient. The report of the administrator of the health facility that has custody of the patient is of critical importance because it includes the details of the offense, the personal history of the patient, his progress since admission to hospital, and the hospital's recommendations. Before the hearing, Board members have access to the file and may also interview the patient. The administrator's report is disclosed to the patient's lawyer and where appropriate, with directions not to disclose it to the patient. Because the recommendation of the Board is advisory only to the Lieutenant Governor-in-Council, it is not the practice of the Board to disclose its recommendations to anyone.

Disclosure may be made after the order of the Lieutenant Governor is completed.

After the hearing, the Board meets *in camera* to prepare the recommendations and to consider whether the patient has "recovered" sufficiently to be transferred to a regional health facility. Although the Board has the legal power to recommend discharge of a patient directly from the hospital to the community, it is the practice to recommend transfer of patients to regional mental health centers for continuing rehabilitation and treatment before discharge. The transfer recommendation involves a weighing of the interests of the patient and the public's interest according to Section 547(5)(d) of the *Criminal Code*. In the event of conflict however, the public interest is clearly paramount.

There are two kinds of disposition derived from Section 545(1) of the *Criminal Code*. The first is a "safely keep" disposition under Section 545(1)(a) and the second is a discharge, either absolutely or on conditions under Section 545(1)(b). Of the safely keep type, the loosened warrant in Ontario is an order which allows the patient to go freely into the community under certain conditions. It involves vesting the administrator of the psychiatric facility where the patient is held discretionary powers to release the patient or to terminate the release. Safely keep, as interpreted by the Ontario Review Board, does not mean being locked up in a maximum security institution. The status of the patients then would seem to reflect degrees of liberty that are related to the hospital's and the Review Board's perception of their mental illness and their danger to society. A loosened warrant is not a discharge, because the administrator of the facility to which the patient is assigned can, based on violations of the conditions of the warrant, order that the patient be returned to the facility, reverting back in some cases to restrictive custody. While it can be argued that such an arrangement may result in longer detention under a warrant (C. Osborne and M. S. Phillips, unpublished data), the point must be made that this conservative approach by the Ontario Review Board and elsewhere in Canada allows the individual gradual reintegration into society and, at the same time, permits the continuity of medical supervision, treatment, and all the other resources necessary to resuming a normal life-style.

Characteristics of Patients Held on Warrants in Ontario

Method All individuals on a warrant of the Lieutenant Governor in Ontario as of April 1, 1982 were included in this study. At the time, the researchers did not know the precise number of patients on warrant in the various institutions.

Procedures All psychiatric hospitals in Ontario were asked to compile

a list of all LGWs officially connected with their hospital (regardless of actual living arrangements) as of April 1, 1982. The lists with patients' names were kept with medical records staff at each hospital at all times—only a code number assigned to each hospital and patient appeared on the completed protocol. The data base for the study was obtained by completing an 11-page protocol which contained items relating to various demographic, psychiatric, and warrant/criminologic information. This information was taken directly from each patient's medical record.

Results

Demographic Information The results showed that slightly more than 90 percent of the LGW population in Ontario are males. There are only 33 females or 9 percent of the population (n = 332). Ninety-five percent of all LGWs were on warrants, having been found not guilty by reason of insanity, and the remaining 5 percent were unfit to stand trial. At the time of this study, there were no mentally ill inmates on warrants of the Lieutenant Governor. Sixty-three percent had been on a warrant for between two and five years and slightly more than 20 percent were living in the community. The rest of the LGWs were attached to a psychiatric facility, with 20 percent being allowed to work in the community during the day.

Two-thirds of both males and females were between the ages of 18 and 35 years when put on a warrant. However, the present age of the LGWs suggests that the males in the population are younger, 65 percent are between the ages of 26 and 45 while 67 percent of the females are between the ages of 36 and 64 (Fig. 1).

Twenty percent of the patients had completed high school and 65 percent were unskilled or semiskilled workers prior to the warrant. Less than 10 percent of the LGWs were employed prior to, but almost 60 percent were

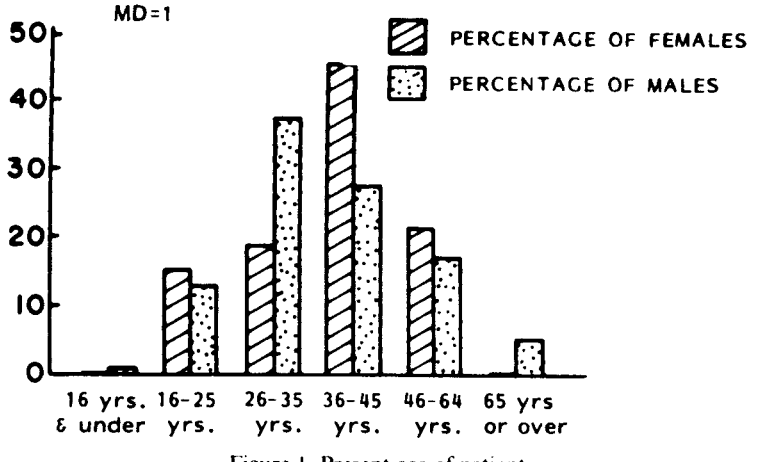

Figure 1. Present age of patient.

unemployed at the time of the offense. Nevertheless, 56 percent of all LGWs were self-supporting, despite the relatively high rate of unemployment. Ninety percent of the patients are Caucasian and 94 percent are Canadian citizens. More than 80 percent of the patients fall within the normal range of intelligence and only 9 percent are estimated to be mildly retarded.

Females, on the whole, were more likely than males to be married or living common law (36 percent versus 19 percent, respectively) at the time of the offense (Fig 2). Similarly, 65 percent of the females were living with relatives (including spouse), while only 52 percent of the males shared similar living arrangements (Fig. 3). Almost two-thirds of both females and males had no children.

Criminal and Psychiatric History The majority of the LGW population had no history of juvenile delinquency or previous criminal charges as adults, although 37 percent had previous charges for property offenses and 29 percent had previous charges for offenses against the person.

Eighty-seven percent of the females and 76 percent of the males had a psychiatric disturbance prior to the warrant (Fig. 4). These values include

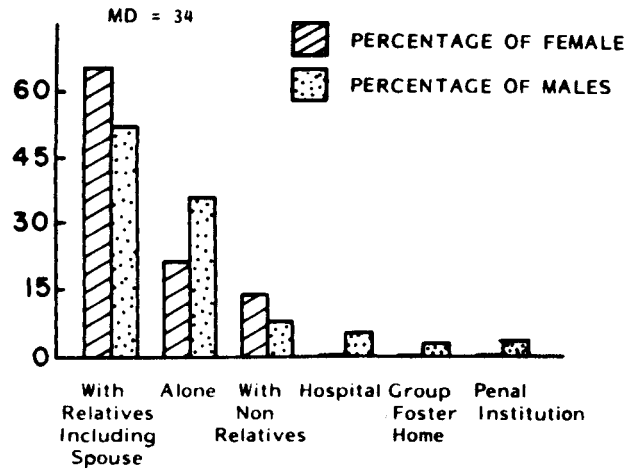

Figure 2. Living status at time of offense.

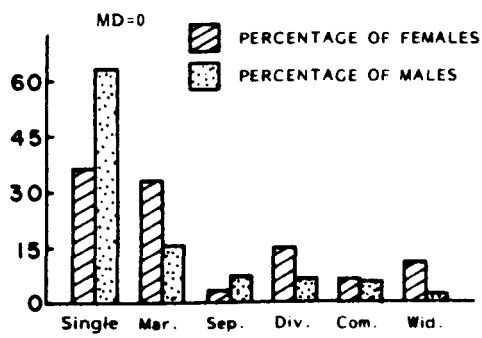

Figure 3. Marital status at time of offense.

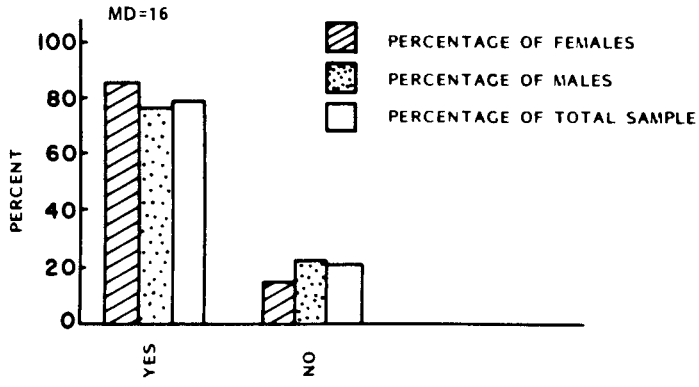

Figure 4. Previous psychiatric disturbance.

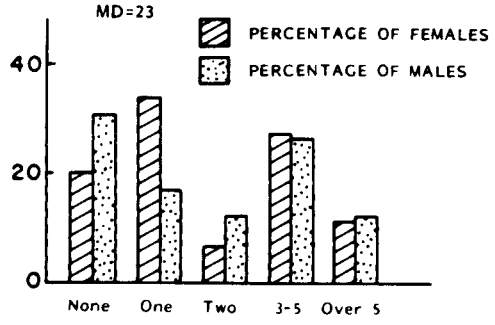

Figure 5. Number of inpatient stays prior to warrant.

both inpatient and outpatient contacts with a psychiatric facility. Females were more likely than males to have had previous psychiatric inpatient experiences (74 percent versus 63 percent, respectively, Fig. 5), but males were more than twice as likely than females to have had previous psychiatric outpatient experiences (64 percent versus 30 percent, respectively). For those patients for whom data were available, we found that more than 50 percent reported psychiatric disturbance in the family, most often in parents (43 percent of the time), siblings (28 percent of the time), and aunts or uncles (19 percent of the time).

Offense-related Data The vast majority of offenses precipitating the warrant were for person offenses. Murder and attempted murder were particularly frequent, constituting 85 percent of the offenses for females and 70 percent of the offenses for males (Fig. 6). Males also had charges of theft (8 percent), sexual offenses (7 percent), and arson (5 percent).

Females were much more likely than males to commit the offense in their own homes (63 percent versus 38 percent, respectively), although approximately 20 percent of the offenses for both sexes occurred in the victim's home (Fig. 7). Females most often victimized their children (41 percent of the time), while strangers were most often the victims of crimes

committed by males (34 percent of the time, Fig. 8). Acquaintances were the next most likely group of victims for both females (25 percent of the time) and males (30 percent of the time), followed by spouses or boyfriends/girlfriends (12.5 percent of the time for females and 12 percent of the time for males).

Of the LGWs who had been prescribed medication at the time of the offense, 75 percent of the males (of a total of 67) and 100 percent of the females (of a total of 10) were not taking the medication when the offense occurred. Almost one-half of the males and 18.5 percent of the females in the total population had a history of alcohol abuse before the warrant. The rate is lower for history of drug abuse in males (37 percent) but higher for females (23 percent). Almost 30 percent of the males were under the

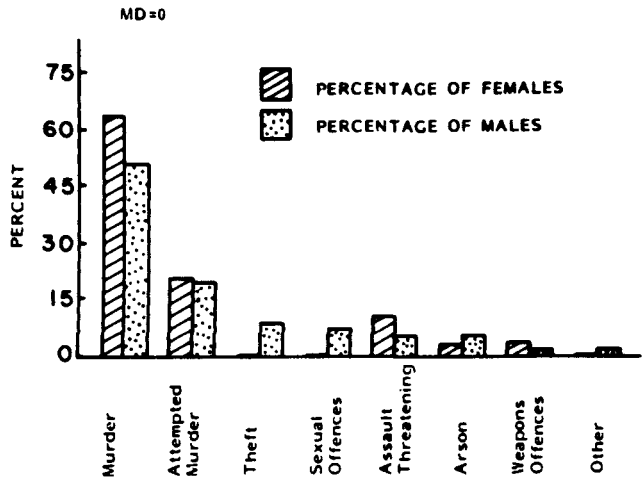

Figure 6. First charge precipitating warrant.

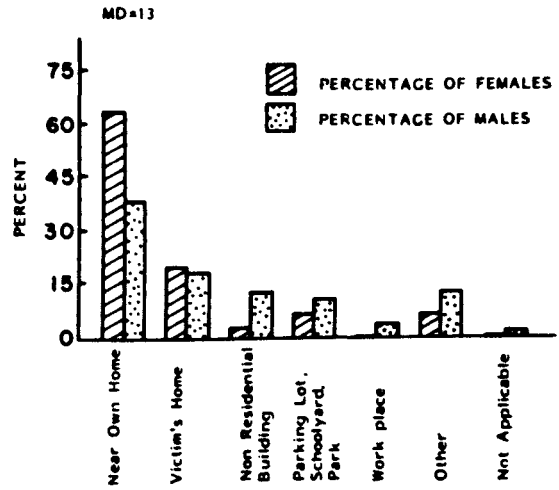

Figure 7. Location of offense.

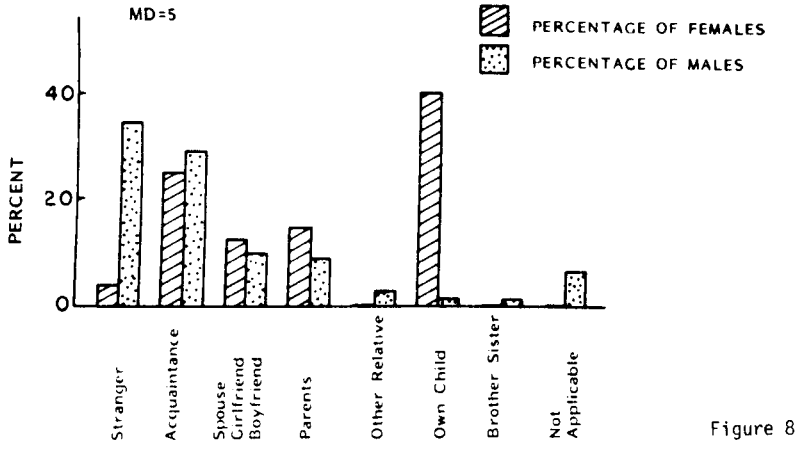

Figure 8. Victim of offense.

influence of alcohol at the time of the offense, while the same is true for only 11 percent of the females. While 14 percent of the males were under the influence of drugs at the time of the offense, no females were in this category.

The psychiatric diagnosis on admission to the psychiatric facility (i.e, when the individual was first put on a warrant) was similar for both sexes. Seventy percent of the females and 69 percent of the males received a diagnosis of some form of psychosis, followed in frequency of personality disorders or neuroses (27 percent of the females and 22 percent of the males). Only two individuals in the population (both males) received diagnoses of "sexual deviation." Analyses of admission and present diagnosis show a shift, with 20 percent of the patients diagnosed as psychotics in remission and two patients designated as not mentally ill (Fig. 9).

Discussion and Conclusions

We have described the Advisory Review Board and presented results of our study of the characteristics of patients on warrants of the Lieutenant Governor in Ontario. To summarize our findings, a patient on a warrant is likely to be found not guilty by reason of insanity, male, age 26 to 35, low educational level, unskilled, and unemployed. He is likely to be charged with a serious offense, namely, murder, and the commission of the crime will be associated with alcohol ingestion. He is likely to have had frequent psychiatric hospitalization and to be diagnosed as schizophrenic.

The two factors of frequent admission to hospital and a diagnosis of schizophrenia point to the treatment problems involved with this group. The deteriorating clinical course of the disease, as well as its episodic nature, could inevitably result in the commission of an offense leading to an LGW. This problem points to a consideration of an urgent need to provide a comprehensive treatment program that includes a restabilization of com-

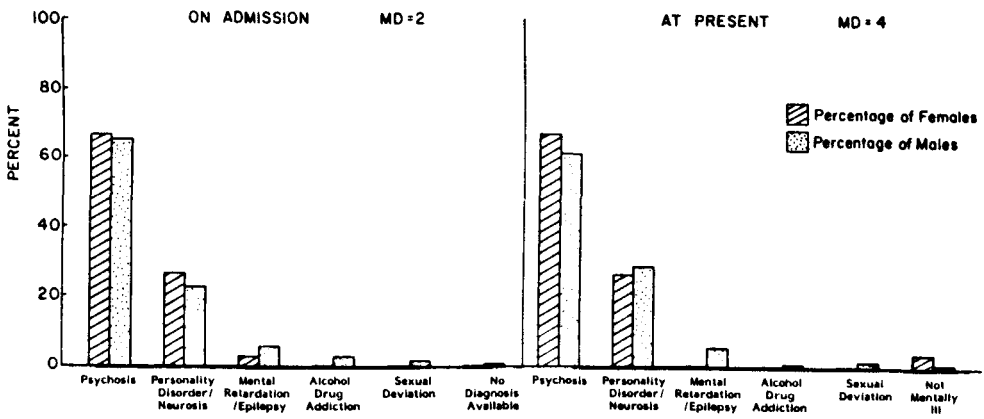

Figure 9. Psychiatric diagnosis on admission and at present.

munity living skills, a continuum of graded facilities, an outpatient care management and services for psychiatric patients. Our unfit population, while small, presents some special problems. Our system makes no distinction between those found unfit and not guilty by reason of insanity, in that they are both captured for different reasons. The focus of confinement for the unfit should be treatment to make him fit and allow him to return to court as soon as possible. In order to ensure this, procedures ought to be in place that would allow more frequent examination of this group of individuals with periodic reporting to the court, which could result in his immediate reappearance in court on the charges laid as soon as he has recovered.

Our study raises a number of questions which, from a policy point of view, have to be answered. (Who wants the mentally ill offender?) While our LGW population is held in psychiatric hospitals, it would appear that our present system of concentrating all LGWs in one location and gradually releasing them disrupts traditional treatment links and separates the patient from his relatives and community support systems. A policy of the least restrictive setting should be considered in the initial disposition of the LGWs. (What is the best mechanism for treatment?) It would appear that a system that is unable to provide differential treatment to adults who are mentally ill, retarded indivdiuals, juveniles, and the elderly is in need of policy review. A policy of the least restrictive setting as well as the appropriateness of the program offered by the facility merits consideration.

Regardless of the decision-making process utilized by the Ontario Review Board, it would seem quite natural to expect that persons with longer criminal histories and diagnoses other than schizophrenia would remain on "full" restricted warrants for long periods. Regardless of whatever system used by the Board in determining full or "loosened" warrants and ultimate release, criticisms on the length of time that patients are detained will force the Board, from a policy point of view, to release or vacate warrants on

terms similar to parole rather than absolute. This will allow continuing supervision of treatment, total release in the community, and the mechanism to ensure that the patient stays out of trouble.

Results reported here raise questions about the system that can only be answered through further research. To fully understand and improve a system as important as this, it is necessary that more effort and resources be directed to increasing our knowledge of the system. Further study of all patients on warrants in Canada is indicated. Other areas requiring attention are: the decision-making process used by the Advisory Review Board in determining release or detention; a follow-up study of all vacated warrants since the inception of the provincial Advisory Review Board; a study of all juvenile LGWs in Canada; and, finally, public knowledge and public attitude surveys of the LGW system. Additional answers in the areas described above will shed additional light on a legal mechanism that has been operating in this country and elsewhere and that is of great importance to us all.

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