Offenders Remanded for a Psychiatric Examination: Perceived Treatability and Disposition

Vernon L. Quinsey* and Anne Maguire**

One of the great debates in criminology and psychiatry is whether criminals should be viewed as mental health problems or whether they should be viewed as "bad." Philosophical considerations aside, the question often becomes a practical one of whether or not offenders are modifiable or "treatable" using methods developed in psychiatric institutions. Some serious offenders, of course, do appear to suffer from severe "mental disorders" and, in Ontario, these have been treated primarily in the Oak Ridge maximum security Division of the Penetanguishene Mental Health Centre which is part of the Ontario Ministry of Health.

Men who have been charged with an offence are sometimes remanded by the courts to a psychiatric facility in order to determine whether they should enter the correctional or mental health system. This decision is based upon a number of considerations: whether (a) the person is fit to stand trial, (b) he was insane at the time of the offence, (c) he is dangerous to others, and (d) he is treatable in a psychiatric institution. A recent Ontario study (Webster, Menzies, & Jackson, 1982) indicated that all of these questions were of considerable interest to provincial court judges. Psychiatrists and psychologists provide advice on these matters to the court which makes the final decision.

Several points should be made about the foregoing description. In law, resolution of the first two issues determine whether the offender enters the health or correctional system. However, determination of the second two issues can importantly modify the offender's disposition. For example, if the offender is viewed as not dangerous and as mentally ill, the charges may be dropped and he can be certified under the Mental Health Act of Ontario and admitted to a regional psychiatric facility. If the offender is viewed as treatable but culpable, he can be sentenced but receive a recommendation that he be treated in a mental health facility. In fact, even if the offender is sentenced without such a recommendation, he can later be transferred to a mental hospital by

* Director of Research, ** Research Psychometrist, Mental Health Centre, Penetanguishene, Ontario LOK 1PO.

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agreement between Oak Ridge and either the provincial or federal correctional systems. There has been continuing criticism of this system and various recommendations for change. The Law Reform Commission of Canada (1975), for example, has advocated Hospital Order legislation which would allow the hospital and a convicted offender to negotiate the admission and course of treatment. In addition, Schiffer (1982) has critically discussed these issues from a legal perspective in some detail.

A number of important questions are raised by the process of determining the disposition of mentally disordered offenders, such as, whether mental health professionals can offer expert advice concerning an offender’s dangerousness or treatability. These questions are important because they involve large numbers of people (165 men were remanded to Oak Ridge alone in 1982), affect the length of confinement for men on indeterminate warrants, affect the length of sentence for those who are eligible for parole, and determine who has access to scarce psychiatric resources. We have studied psychiatric determinations of dangerousness extensively (Pruesse & Quinsey, 1977; Quinsey, 1975, 1979; Quinsey & Ambtman, 1978, 1979) but there have been few studies of the treatability of mentally ill offenders. How do forensic clinicians decide who gets treatment? Do the courts listen to their advice? Can clinicians predict which offenders will and will not benefit from treatment? These questions have received little empirical study despite their ethical and economic implications.

It should be noted in this connection that, in Canada, the provincial Ministries of Health and the courts have considerable leeway in what type of offenders are admitted to the mental health system. For example, a survey of persons found not guilty by reason of insanity or unfit for trial conducted in 1975 found that, in Ontario, the percentages of personality disorders and psychotics were 27 and 61, whereas, in Quebec, the percentages were 5 and 76, respectively (Quinsey & Boyd, 1977). Other characteristics of mentally ill offenders also varied widely across the provinces.

The purpose of this study is to examine assessments of the treatability of mentally disordered offenders and to determine which offender and offence variables are related to the outcome of these assessments and the extent to which the psychiatric reports are related to judicial decisions.

**Method**

*Remands*

Two hundred consecutive remands to the Oak Ridge Division of the Penetanguishene Mental Health Centre from July 1978 to September 1980 were studied. One hundred and ninety offenders were remanded by the court for a pretrial psychiatric assessment and ten for a posttrial assessment on the issue of sentencing. All subjects were male. The characteristics of the sample studied are shown in the first 10 rows of Table 1. In summary, Table 1 shows that the sample was composed of relatively young, poorly educated, primarily personality disordered men charged with serious offences.
### TABLE 1
Characteristics of Sample and Recommended Dispositions

<table>
<thead>
<tr>
<th>Variable</th>
<th>Diagnosis¹</th>
<th>Total (includes 7 others)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Personality Disorder</td>
<td>Psychosis</td>
</tr>
<tr>
<td>1. Number</td>
<td>118</td>
<td>60</td>
</tr>
<tr>
<td>2. Mean age on admission (S.D.)</td>
<td>26.65 (9.37)</td>
<td>31.10 (9.86)</td>
</tr>
<tr>
<td>3. Mean highest grade completed (S.D.)</td>
<td>9.03 (2.26)</td>
<td>9.88 (2.47)</td>
</tr>
<tr>
<td>4. Percent any college or university</td>
<td>13</td>
<td>30</td>
</tr>
<tr>
<td>5. Percent ever married</td>
<td>45</td>
<td>40</td>
</tr>
<tr>
<td>6. Percent no occupation</td>
<td>54</td>
<td>65</td>
</tr>
<tr>
<td>7. Percent previous corrections</td>
<td>41 (N = 116)</td>
<td>23</td>
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<tr>
<td>8. Percent previous psychiatric hospitalizations</td>
<td>49 (N = 116)</td>
<td>75 (N = 59)</td>
</tr>
<tr>
<td>9. Percent previous Oak Ridge admission offence (percent)</td>
<td>16</td>
<td>32</td>
</tr>
<tr>
<td>a) Homicide</td>
<td>20</td>
<td>22</td>
</tr>
<tr>
<td>b) Nonsexual vs persons</td>
<td>31</td>
<td>28</td>
</tr>
<tr>
<td>c) Sexual</td>
<td>25</td>
<td>7</td>
</tr>
<tr>
<td>d) Property</td>
<td>8</td>
<td>8</td>
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<tr>
<td>e) Other</td>
<td>16</td>
<td>35</td>
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<td>a) Treatment</td>
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<td>97</td>
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<tr>
<td>b) Health stream</td>
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<td>48</td>
</tr>
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<td>11. Letter recommendations (percent)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Fit</td>
<td>98 (N = 100)</td>
<td>91 (N = 55)</td>
</tr>
<tr>
<td>b) Bail</td>
<td>9 (N = 115)</td>
<td>10 (N = 58)</td>
</tr>
<tr>
<td>c) Insanity Defence</td>
<td>4 (N = 80)</td>
<td>42 (N = 36)</td>
</tr>
<tr>
<td>d) Treatment</td>
<td>71 (N = 65)</td>
<td>98 (N = 51)</td>
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<tr>
<td>12. Court disposition (percent)</td>
<td></td>
<td></td>
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<tr>
<td>a) NGRI WLG</td>
<td>6 (N = 117)</td>
<td>38 (N = 58)</td>
</tr>
<tr>
<td>b) Corroctional sentence</td>
<td>66 (N = 117)</td>
<td>21 (N = 58)</td>
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<tr>
<td>c) Treatment</td>
<td>36 (N = 116)</td>
<td>74 (N = 57)</td>
</tr>
<tr>
<td>d) Health stream</td>
<td>6 (N = 106)</td>
<td>46 (N = 48)</td>
</tr>
</tbody>
</table>

¹ Diagnosis is the primary diagnosis given by the attending psychiatrist at discharge or case conference. Previous hospitalizations excludes previous admissions to Oak Ridge and previous Oak Ridge admissions excludes admissions on the same charge. Homicide includes any offence which involved the killing of another person. Armed robbery was considered an offence against persons whereas robbery was included as a property offence. Ever married includes common-law arrangements. N's are inserted where there are missing (usually unknown) data.
Conference Participants

Each remand was conferenced by an interdisciplinary team. Because the individuals who attended each conference varied, only physicians, psychologists, and those attending 60 conferences or more were included for analysis; only those attending more than 60 conferences were used in analyses of interclinician agreement. This sampling method included those who most frequently attended and those most likely to give courtroom testimony. Four psychiatrists attended 196, 91, 6, and 3 conferences, respectively; four psychologists attended 173, 11, 10, and 5; two social work assistants attended 126 and 93; one attendant attended 120; two social workers attended 95 and 68; one nurse attended 67; and three physicians attended 16, 5, and 1 conference, respectively.

Measures

Conference. Each conference participant filled out a Remand Assessment Questionnaire during or immediately after the conference; thus, the ratings were usually completed after extensive group discussion. The first question read, “What type of post-trial treatment(s) would benefit this remand’s clinical status, if any? For each type of treatment which is relevant to the remand’s clinical status, how much improvement would he be likely to make during a 2-year (or less) period? Assume all are equally available. The goals of treatment would include reducing the probability of recidivism and a reduction in psychiatric symptomatology.” After each treatment type there was a box marked “irrelevant” and a nine point scale labelled “expected amount of improvement” ranging from 1 (slight) to 5 (moderate) to 9 (great). The treatment types were: phenothiazine medication, ECT, antiepileptic drugs, milieu therapy, ward token economy, aversion therapy, social skills or assertion training; vocational training, psychoanalysis, group therapy, individual counselling, passage of time, correctional placement, minor tranquillizers, marital counselling, intensive encounter groups, defence disrupting drugs, and other.

Six 9-point rating scales followed, which measured (a) how much insight the remand had into the nature of his illness, (b) how genuinely motivated he was for treatment, (c) how dangerous to others he was, (d) how psychotic he was, (e) how personality disordered he was, and (f) given the optimal treatment program, how much improvement he was likely to make in a 2-year period. Item F was the measure of general treatability.

The final question was “Assuming that the remand committed the alleged offence, what disposition of this case would you make if the decision were left to you?” Nine alternatives followed: probation with or without out-patient treatment, correctional placement with or without psychiatric treatment, return to Oak Ridge, community diversion without probation or treatment, community diversion without probation but with treatment, in-patient treatment in a minimum security psychiatric hospital, and other.

Letter to court. The psychiatrist in charge of each case invariably wrote a letter to the court describing his findings. This letter was sometimes supplemented by court testimony by the psychiatrist and/or the psychologist assigned to the case but this testimony was not part of our data set.
Each letter to the court was examined and it was determined if: bail was specifically recommended, recommended against, or not mentioned; the insanity defense was thought applicable (yes, no, no mention); the remand was thought to be dangerous; and, finally, if the prognosis was good, poor, uncertain, or not mentioned. The recommended disposition of the case was recorded: psychiatric treatment, return to Oak Ridge, return to community with some intervention, further assessment, or no treatment.

Disposition. The crown attorneys for each case were contacted by mail and/or phone to determine the disposition the court had made. The first follow-up data were gathered in December of 1980 and 90% of the material was complete in August of 1981; the remaining 10% was not obtained until May of 1982. The follow-up time was about 12 months for most remands (range 4–47 months). The verdict was determined (guilty, not guilty, warrant outstanding, not guilty by reason of insanity, unfit, or not finished in court). If the offender was found guilty, the sentence was recorded. It was also determined whether some recommendation for treatment was made by the court. As well, the Oak Ridge records were examined to find whether a remanded offender had been returned to Oak Ridge.

Analysis

Because different clinicians attended different conferences, the Remand Assessment Questionnaire data were handled in several different ways. For each rated variable, all analyses were performed on: the average response of all conference participants for each conference, the average of all psychiatrists and psychologists, and the individual responses of the psychologist and psychiatrist who attended the most conferences. Interrater agreement analyses (Pearson r's for rated variables and kappas for categorical variables) were computed for each pair of participants who attended 60 or more conferences based on the conferences that they had both attended.

All rated variables were intercorrelated. Treatability and dangerousness were each predicted from the demographic variables in Table 1 using stepwise multiple regression. This analysis involved 15 predictors, 5 of which were continuous and the remainder dichotomous. Stepwise regression equations were used to predict both dangerousness and treatability from the six 9-point scales on the Remand Assessment Questionnaire.

The files and letters to the court of 40 randomly selected remands were examined by two raters who independently coded the information used in this study. Agreement indices were satisfactory for all variables coded (the correlations and kappas were all above .70, most in the .85 to 1.0 range, and all percent agreements were above 70, mostly in the nineties).

Results

Conference Data

Nine clinicians attended 60 or more conferences. For ratings of the treatability of each remand, the interclinician correlations varied from .04 to .75 with an average of .43 (SD = .12). For the dangerousness ratings, the correlations
ranged from .19 to .71 and averaged .53 (SD = .16). Disposition was divided into six categories: probation, corrections, Oak Ridge, community diversion, in-patient, and other. Interclinician kappas for disposition ranged from .15 to .70 and averaged .44 (SD = .12).

The means of and intercorrelations among the six rated variables of the Remand Assessment Questionnaire for all raters are shown in Table 2. As a group, the remands were seen as rather dangerous and personality disordered but not as good treatment candidates. The motivation and insight items were very highly correlated and appeared to be measuring the same phenomenon.

The agreement on degree of psychosis and degree of personality disorder was high. For example, the ratings of the psychiatrist and psychologist who attended the most conferences correlated .83 (n = 163) for psychosis and .69 (n = 163) for degree of personality disorder.

A stepwise regression analysis based on all raters showed that expected improvement was best predicted by rated degree of personality disorder and by perceived motivation for treatment. The addition of the other variables did not add any predictive power. With the first 2 variables r was .81 and only rose to .83 with all variables. A similar finding was obtained in predicting dangerousness. The first variable entered was degree of personality disorder and the second was degree of psychosis; no other variables were important; a multiple r of .58 was obtained with 4 variables (.56 with the first two).

Perceived treatability (average of all raters) was also predicted by the demographic and clinical variables in Table One. A multiple r of .71 was obtained but only three variables contributed more than 4% change in the variance accounted for. In order of declining importance, these were a diagnosis of personality disorder (r = -.59), number of previous correctional placements (r = -.35), and a diagnosis of retardation (r = -.02). Perceived dangerousness (average of all raters) was predicted by an offence involving homicide (r = .35), a property offence (r = -.33), and number of previous correctional placements (r = .23). The overall r was .60 and the r obtained with the first 3 variables was .52, with no other variables adding more than 4% of the variance.

| TABLE 2 |
| Averages and Intercorrelations for Rated Variables (average of all raters) |

<table>
<thead>
<tr>
<th></th>
<th>Personality Disorder</th>
<th>Psychosis</th>
<th>Motivation</th>
<th>Insight</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Expected improvement</td>
<td>3.06 1.24</td>
<td>-.29</td>
<td>-.71</td>
<td>.55</td>
</tr>
<tr>
<td>2. Dangerousness</td>
<td>5.24 1.58</td>
<td>.46</td>
<td>.02</td>
<td>-.07</td>
</tr>
<tr>
<td>3. Personality disorder</td>
<td>5.13 1.61</td>
<td>-.55</td>
<td>-.38</td>
<td>-.37</td>
</tr>
<tr>
<td>4. Psychosis</td>
<td>2.31 1.77</td>
<td>.27</td>
<td>.13</td>
<td></td>
</tr>
<tr>
<td>5. Motivation</td>
<td>2.33 1.18</td>
<td>.86</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Insight</td>
<td>2.58 1.15</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
OFFENDERS REMANDED FOR A PSYCHIATRIC EXAMINATION

TABLE 3
Interrater Agreement on Expected Degree of Improvement

<table>
<thead>
<tr>
<th>Treatment Modality</th>
<th>Correlations Pooled Over 1711 Observations</th>
<th>Most Optimistic Pair (n = 51)</th>
<th>Most Senior Pair (n = 149)</th>
<th>Pooled Correlations for Psychotics Only (n = 544)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Phenothiazines</td>
<td>.728</td>
<td>.833</td>
<td>.868</td>
<td>.439</td>
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<tr>
<td>2. Aversion Therapy</td>
<td>.326</td>
<td>.487</td>
<td>.343</td>
<td>.096</td>
</tr>
<tr>
<td>3. Group Therapy</td>
<td>.238</td>
<td>.243</td>
<td>.244</td>
<td>.246</td>
</tr>
<tr>
<td>5. Social Skills or Assertion</td>
<td>.167</td>
<td>.302</td>
<td>.224</td>
<td>.147</td>
</tr>
<tr>
<td>6. Milieu Therapy</td>
<td>.143</td>
<td>.180</td>
<td>.463</td>
<td>.048</td>
</tr>
<tr>
<td>7. Passage of Time</td>
<td>.112</td>
<td>.153</td>
<td>.165</td>
<td>.064</td>
</tr>
<tr>
<td>8. Token Economy</td>
<td>.098</td>
<td>.653</td>
<td>.099</td>
<td>.053</td>
</tr>
<tr>
<td>9. Vocational Training</td>
<td>.095</td>
<td>.188</td>
<td>.145</td>
<td>.175</td>
</tr>
<tr>
<td>10. Individual Counselling</td>
<td>.090</td>
<td>.053</td>
<td>.185</td>
<td>.060</td>
</tr>
</tbody>
</table>

1 Includes only remands diagnosed as personality disordered or psychotic.

Specific treatment type ratings were examined for the nine clinicians who attended 60 or more conferences. Relatively few treatments were judged to be more than moderately effective: phenothiazines (in 18% of the cases), passage of time (16%), corrections (12%), vocational training (11%), social skills (10%), group therapy (8%), and individual counselling (9%). In fact, most of the treatment types were judged to be irrelevant most of the time. Averaging over all raters, minor tranquilizers and psychoanalysis were judged to be irrelevant in over 90% of the cases. Corrections, individual counselling, and the passage of time were the most frequently advocated (being judged irrelevant in between 49% and 56% of the cases). There were marked individual differences in clinicians' pessimism about treatment. At the extremes, the attendant participant thought that, on average, each treatment was irrelevant 94% of the time; at the optimistic end, a psychologist and a nurse believed the treatments to be irrelevant 68% of the time.

To examine the issue of interclinician agreement on specific treatments, the ratings of each possible pair among the nine clinicians were correlated with each other on each of the treatment type variables using data from the conferences they both attended. Average interclinician correlations were obtained by weighting each interclinician correlation by the number of conferences on which it was based. These averages are shown in Table 3. As can be seen in Table 3, only judgments of the degree of improvement to be expected with phenothiazines showed good inter-judge congruence.

Before the finding of poor agreement on treatment type efficacy can be accepted, several alternative interpretations of the data must be excluded.
Because most treatments were not seen as particularly beneficial, it might be argued that the correlations were low because of a restriction of range artifact. As can be seen in Table 3, however, a comparison of the two most optimistic clinicians (a psychologist and a nurse) indicated only modest improvement in agreement. Similarly, ratings of those remands who were diagnosed as psychotic and hence who would most likely be considered to be treatable yielded lower rates of agreement (Table 3). A further argument could be that the poor agreement simply reflected differences in experience or training among the clinicians. This interpretation does not appear valid: The most “senior” pair of raters both in terms of responsibility for the majority of the cases and the largest number of conferences attended (a psychiatrist and psychologist) did not show appreciably higher levels of agreement than those found when pooling over all raters; the pair of psychiatrists who attended more than 60 conferences similarly showed no higher level of agreement.

A further possible objection to these agreement data is that the treatments, with the exception of phenothiazines, were ill specified and the poor agreement simply reflects the vagueness of the categories. Several factors make this an implausible interpretation: (a) each of the treatments listed, excluding psychoanalysis and marital therapy, has existed within Oak Ridge in a well defined program structure; (b) the treatment types listed are those which are in fact recommended for offenders; and (c) combining the treatment types into broader categories did not improve agreement. This latter analysis involved combining the treatment types into three categories: somatic (phenothiazines, ECT, antiepileptic medication, and minor tranquilizers), psychotherapeutic (milieu therapy, group therapy, counselling, encounter groups, and marital therapy), and behavioral (aversion therapy, token economy, and social skill). The psychologist and psychiatrist who had attended the most conferences (the senior pair of raters) were used in this analysis; for each conference which they both attended it was determined whether all of the treatments within a category were marked irrelevant. If such was the case, the category was scored as irrelevant and not otherwise. Percent agreements for the irrelevancy of treatment categories for personality disorders (n = 99) was 82% (somatic), 39% (psychotherapeutic), and 42% (behavioral). For psychotics, the percent agreements were 61% (somatic), 35% (psychotherapeutic), and 49% (behavioral). The corresponding kappas were low (ranging from −.041 to .355). Thus there was poor agreement even with the broadened categories and liberal scoring system.

The final alternative explanation of these findings to be considered is that the specific treatment types were marked at random because the raters did not attend to or understand the task. The specific treatment type data did, however, appear to be lawful even though the clinicians did not agree. For example, the mean ratings for most treatment types were lower for personality disorders than for psychotics; especially in the case of phenothiazine effectiveness (and, of course, subjects did agree on this variable). Differences among clinicians which appeared in overall ratings of treatability were reflected in ratings of the effectiveness of individual treatment types. For example, the most senior pair of raters differed in their pessimism about overall treatability and, as expected, the more optimistic clinician was more optimistic about each of the
specific treatment types. These differences were not always significant as, for example, with phenothiazine effectiveness, but were sometimes enormous. The largest involved the benefits of the passage of time (t for matched pairs, [d.f. = 148] = 11.04, p < .001, based on conferences of personality disordered or psychotic offenders which both attended).

In order to make the results more concrete, brief descriptions of the individual remands perceived as most and least dangerous and the remands perceived as most and least treatable are given below. The remand seen as most dangerous received the following average ratings by the entire conference team: insight (1), motivation (1), dangerousness (8.5), degree of psychosis (1), degree of personality disorder (7.2), and amount of expected improvement (1.5). This 25-year-old single man was charged with second degree murder; he had killed a man with a shotgun following a group fight outside of a tavern. His criminal career involved early breaking and entering charges and he received grade 10 in training school. He was later expelled from a vocational school for fighting with the teachers. He worked in construction and in the winter was employed as a tavern doorman. During his late teens and early twenties he was charged with assault, wounding with intent, obstructing police (3 times), failing to appear, attempted theft, and several liquor act offences.

The least dangerous remand received ratings of 3.4 (insight), 2.4 (motivation), 1.4 (dangerousness), 1.4 (degree of psychosis), 3.0 (degree of personality disorder), and 4.4 (expected improvement). This 18-year-old man was charged with theft, willful damage, and possession of a dangerous weapon. The incident involved the theft of a canoe, knocking over a motorcycle, and brandishing a stick at police officers. The offence had occurred some time before his appearance at Oak Ridge. Immediately after the offence, he had been put in a local jail where his “bizarre thought patterns” caused him to be sent to a psychiatric hospital from which he eloped and lived without further incident for several months. He had no previous record, appeared psychiatrically normal at Oak Ridge, and had been doing well at school during his elopment.

The remand seen as most treatable received ratings of 3.1 (insight), 2.7 (motivation), 3.6 (dangerousness), 3.4 (degree of psychosis), 5.6 (degree of personality disorder), and 6.4 (expected improvement). He was a 36-year-old skilled laborer who was charged with assaulting a police officer after he resisted the policeman’s attempt to move him out of a drinking lounge. He subsequently hit another patient in a regional psychiatric hospital to which he had been sent after breaking his bail conditions by drinking. He was sent to Oak Ridge after being arrested again and being assaultive in jail. This patient had had periodic attacks of mania over the past several years and had responded well to lithium.

The remand seen as least treatable received average ratings of 1.3 (insight), 1.0 (motivation), 7.0 (dangerousness), 1.0 (degree of psychosis), 8.0 (degree of personality disorder), and 1.0 (expected improvement). He was an 18-year-old man charged with attempted murder of his 28-year-old girlfriend. He stabbed the victim with no warning or previous interaction as she lay in bed early in the morning. He stole her car and was apprehended by the police. While at Oak Ridge he denied stabbing her and couldn’t understand why she had accused him. He claimed he had tried to phone for an ambulance after
he found her stabbed but was all choked up and couldn’t speak. His account of the crime, personal history, and complaints of various psychological symptoms (including amnesia and hallucinations) varied daily. His previous record included auto theft.

Letter to the Court

As shown in Table 1, the psychiatrist’s letter to the court almost always indicated that the remand was fit for trial, usually indicated that the insanity defence was not applicable, seldom recommended bail, and suggested treatment about half of the time.

Court Disposition

The disposition and follow-up data are presented in Figure 1. As can be seen, 74% of the remands were found guilty and none unfit for trial. During the follow-up period, 45 remands returned to Oak Ridge, 8 of these with new charges. It is of interest that nine of the remands who had been found guilty were returned to Oak Ridge without new charges. All WLGs were returned to Oak Ridge save two: one (not shown in the figure) who was admitted to a medium security facility and another who committed a new offence while on a WLG and was sentenced to prison. One person sentenced to life was remanded to Oak Ridge for a previous offence.

**FIGURE. 1.** Disposition of offenders remanded to Oak Ridge.
TABLE 4
Agreement Between Psychiatrist's Letter to the Court and the Court Judgment on Section 16 and Treatment

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<td>Court Judgment</td>
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<td>Total</td>
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<tr>
<td>Court Judgment</td>
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<tr>
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<td>Total</td>
<td>107</td>
<td>78</td>
<td>185</td>
<td></td>
</tr>
</tbody>
</table>

Note: Cases are included where the information was clear in both the letter and the court judgment.

Relation Between the Psychiatrist's Letter and the Court Judgment

Table 4 shows the relation between the psychiatrist's letter to the court and the court judgment on whether the insanity defence was applicable and whether treatment should be tried. The court and letter showed high agreement as to the insanity defence \( \chi^2(1 \text{ d. f.}) = 53.92, p < .0001; \text{Kappa} = .685 \) but the amount of agreement on the treatment recommendation, although significant, was of small magnitude \( \chi^2(1 \text{ d. f.}) = 9.53, p < .01; \text{Kappa} = .202 \). In this connection it should be noted that the primary questions of interest for the majority of remand assessments were fitness and the insanity defence. As well, it must be remembered that opposing psychiatric testimony on all issues was often presented in court.

Discussion

The interclinician agreement on how dangerous the remanded patients were was moderate; this finding replicates our earlier studies on prediction (Quinsey, 1975; Quinsey & Ambtman, 1978, 1979). The clinicians agreed among themselves less about the remands' treatability. The variability among the correlations on both variables is rather disturbing. Similarly, the absolute magnitude and variability of the interclinician kappas for recommended disposition were not encouraging. The fact that these correlations were obtained after extensive discussion of the cases emphasizes the lack of precision in the judgments.

The data, however, become alarming when we consider type of treatment. Surprisingly, the interclinician agreement for recommended type of treatment was extremely low with the exception of the efficacy of phenothiazines. The agreement on the efficacy of phenothiazines is encouraging but must be tempered by the findings that there are marked discrepancies in psychiatrists' prescriptive policies for psychoactive drugs; individual psychiatrists have been found to disagree with each other about dose level and type of medication and to be
inconsistent themselves on these issues (Gillis & Moran, 1981). Clearly, there is no consensus among clinicians even after a case has been discussed as to whether any particular treatment other than phenothiazines is relevant for a particular remand or as to how much he might benefit from a particular treatment. The implications of this finding for nondrug treatments are profound. If no consensus exists, how can an institution rationally organize a treatment program or assign patients to particular subprograms? Even more disturbing is the spectre of what a psychiatrist’s or psychologist’s testimony in court regarding treatment recommendations really means. Given the lack of agreement, it is at best an arbitrary pronouncement.

Because of the importance of this issue and the radical implications of our findings, replication is clearly called for. These data, however, cannot be dismissed lightly; Oak Ridge receives the most serious cases for psychiatric assessment in Ontario and the clinicians who participated in this study are among the most experienced anywhere. Moreover, Oak Ridge provides the bulk of treatment programming for men found not guilty by reason of insanity in Ontario. In addition, similar observations have appeared before. Greenland and Rosenblatt (1972) noted large discrepancies over the various Ontario hospitals in whether inpatient treatment was recommended for remanded offenders. In a study of remanded patients conducted at Oak Ridge 10 years ago, Quinsey (1975) found marked disagreements among staff in ratings of whether remands would benefit from treatment; specifically, attendant staff were much more pessimistic about treatment response than other staff categories (a pattern of data similar to that found in the present study). More recently, Webster, Menzies, and Jackson (1982) found that in their sample, psychiatrists disagreed among themselves concerning the treatability of remanded offenders. It is, of course, a separate question as to whether those who are recommended for treatment and receive it are, in fact, good treatment candidates. Bowden (1978) found that, among offenders remanded to Brixton prison in England, 13% were recommended for and received treatment but that 62% of these cases did not benefit from the treatment therapeutically.

Despite the poor agreement on treatability and on the relevancy of particular types of programs, it is clear that there is profound pessimism about treatment efficacy. This pessimism is most marked in connection with personality disordered offenders. In the prediction of treatability ratings from file data, diagnosis of personality disorder was highly and negatively correlated with treatability ratings. Rated degree of personality disorder was also highly related to low treatability ratings in the conference data. It appeared that the clinicians sorted the offenders into personality disordered and psychotic categories; the personality disordered offenders were seen as essentially untreatable and the psychotic offenders were thought to respond to phenothiazines. Although there are no convincing data one way or the other, it is common folklore that personality disordered offenders are untreatable. Given the psychiatric community’s belief about such offenders, it is quite clear that few of them will in fact receive treatment.

Pervasive pessimism about treatability may well be responsible for the failure of forensic clinicians to routinely consider various treatment options in specific and concrete terms and to systematically gather data which would allow for
treatment decisions to be made on rational grounds. It is important to realize that the issue of treatability is not necessarily related to that of diagnosis; in the present study, agreement on degree of personality disorder and psychosis was high but, nevertheless, the agreement on treatability was low.

Considering the lack of consensus regarding treatability, the posttrial “slippage” of offenders between the correctional and health streams may be a positive outcome. The amount of slippage was small in the present study but the follow-up time was only a year for most remands. This movement of offenders back and forth between health and corrections for various reasons has been documented by others (e.g. Webster, Menzies, & Jackson, 1982) and can be regarded as a real and important phenomenon. It may well be that treatment decisions are best made after the offender has been observed in a correctional or psychiatric setting for a period of time. With respect to mentally disordered offenders, it has been noted (Quinsey, 1979) that a verdict of not guilty by reason of insanity does not mean that a treatment for the “insanity” is currently available. A flexible arrangement whereby an offender and a psychiatric institution can negotiate the length and type of treatment appears very desirable. A similar arrangement would, of course, be desirable for those offenders found guilty and who want and need psychiatric treatment.

References


