

**A Rake's Progress in a New Politics of Risk: Examining the Construction of Risk and
Mental Disorder in Not Criminally Responsible on Account of Mental Disorder (NCRMD)
Disposition Hearings in Ontario**

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Abstract

In Canada, individuals accused of a criminal offence can raise a defence of Not Criminally Responsible on Account of Mental Disorder (NCRMD), stating they were suffering from a mental disorder that rendered them incapable of appreciating the nature or quality of the act, or of appreciating that it was wrong. Individuals found NCRMD are then rendered under the jurisdiction of a provincial mental health review board tasked with evaluating whether or not the individual represents a significant risk to the safety of the public.

This study adopted a methodological approach using qualitative content analysis to investigate the construction of risk in the decision-making process of the Ontario Mental Health Review Board (ORB). Results from the analysis of 30 printed rationales for decision, the justificatory document for any disposition made by a review board, indicate some ambiguity in conceptualizing risk and justifying the dispositions made by the ORB. In an effort to open the black-box of these justificatory documents, this study notes the objectivity effect of a medicalized language that obfuscates understanding of terms used by the ORB to justify risk assessments. Ultimately, the complexity of the notion of risk is reduced to a function of medical-biological psychiatric diagnostics and intervention, community or social normativity, and secondary risk management (defensive decision-making by professionals involved in the review process). These interpretations are then discussed in terms of policy implications under a new politics of uncertainty (Power, 2004).

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*“Look at your body –
A painted puppet, a poor toy;
Of jointed parts ready to collapse;
A diseased and suffering thing;
With a head full of false imaginings”
– The Dhammapada*

Introduction

In Canada, three recent high-profile homicide cases involving individuals diagnosed as suffering from severe mental disorders and later found Not Criminally Responsible on Account of Mental Disorder (NCRMD), have seen wide-spread media coverage and commentary from the public (Dempsey, 2014; Grantham, 2014). In April of 2008, Allan Schoenborn murdered his three children because he said he feared they were being sexually and physically abused by his ex-wife’s current partner, and he hoped to save them from further humiliation (Hunter, 2010). In July of 2008, Vincent Li beheaded and cannibalized Tim McLean, a fellow Greyhound bus rider (CBC News, 2008). In February of 2009, Guy Turcotte¹, a cardiologist working in Quebec, repeatedly stabbed his two children to death while they slept (CBC News, 2011). These three individuals were found NCRMD at trial and rendered under the jurisdiction of their respective provincial Mental Health Review Boards because it was determined that due to a mental disorder at the time of the offence they were unable to appreciate that the actions they took were wrong.

Individuals found NCRMD are typically referred to provincial review boards and placed in a forensic psychiatric hospital for treatment and management of their disorder until such time as they may be released, at the satisfaction of the review board, when they no longer represent a significant risk to the safety of the public. Cases involving mentally disordered individuals and

¹ The Guy Turcotte case was later successfully appealed by the prosecution, arguing that the trial judge had erred in rendering the NCRMD verdict. Guy Turcotte was convicted of second-degree murder in December, 2015 (CBC News, 2016). Importantly, this particular case highlights the complexity underlying the conceptualization and application of the notions of mental disorder and cognition with respect to criminal responsibility faced by the legal and mental health fields.

NCRMD cases in particular, highlight for many a profound concern with the lack of clarity surrounding severe mental illness, its relation to crime or responsibility, and the potential for individuals to escape “just punishment” by deploying an NCRMD defence (Dallaire, McCubbin, Morin, & Cohen, 2000; Whitley & Berry, 2013). These three cases, initially adjudicated as NCRMD, were framed by the public and the federal government as dangerous individuals given an inadequate sentence based on their presumed mental status (openparliament, 2013; Burgmann, 2015; Whitley & Berry, 2013). Recent subsequent changes to the NCRMD legislation highlight the focus on public safety and the management of risk posed by those deemed potentially dangerous, citing these particular cases as an impetus for change. Bill C-14 came into force July 11, 2014, creating a new “high-risk” category of NCRMD accused, as well as extending mandatory review periods for the review boards to up to 3 years, from a previous maximum of 1 year (Bill C-14, 2014).

Significant research suggests, however, that on the whole individuals suffering from severe mental disorders are more likely to be victims of violence than they are to perpetrate it, including lower attendant rates of general crimes, violent crimes, general recidivism, and violent recidivism in the community compared with the general population (Crocker et al., 2015b; Charette et al., 2015). Importantly, the recent NCRMD policy changes are an *ex post facto* response insofar as the individuals committing the acts were not previously NCRMD and then released into the community – the implication being that systemic and legislative changes have been implicated in issues of reactionary strategies for those seeming to suffer from severe mental disorders and are convicted of a crime. Logically, the concern would be toward issues in the mental health system somehow neglecting or diverting cases which then become problematic in a criminal sense – rather than a response through reforms to NCRMD legislation. Regardless,

changes in criminal justice policy are heavily implicated with the mental health system and its conceptualization of criminal responsibility and the evaluation of conduct (Klassen, 2016; Szasz, 2002). Proponents of the recent Bill C-14 legislation advocated for change suggesting the need to bolster the Criminal Code to protect the safety of the public from the potential danger posed by the mentally ill (Grantham, 2014). Opponents, however, suggested the policy changes were impulsive and punitive, a violation of the Charter of Rights and Freedoms (Dempsey, 2014; Grantham, 2014). Of particular salience here is that opponents suggest the pre-July 2014 framework balanced the safety of the public with the needs of the NCRMD population, considering it fair and emancipatory.

At an organizational level, the criminal justice system mobilizes psychiatry in establishing issues of capacity, understanding and volition, essential to our understanding of criminal responsibility and rationality. The interface between law and psychiatry is reproduced through systems of knowledge, discourse and techniques underlying their respective institutions. This thesis wishes to investigate a particular manifestation of that interface through an examination of recent praxis of the provincial mental health review board in Ontario, in order to develop a more nuanced understanding of the conceptualization of, and discourse surrounding, risk and its application in forensic psychiatric cases.

Review Board System in Canada

It is instructive to detail the development and legislative structure of Mental Health Review Boards (review boards) across Canada in order to more clearly investigate the Ontario Review Board's (the Board) policies and praxis.

The defence of Not Criminally Responsible on Account of Mental Disorder (NCRMD) is raised in cases where individuals are said to have had a mental disorder at the time of their offence that resulted in their being unable to form the appropriate *mens rea* or "guilty mind" at that time (Verdun-Jones, 2014). Generally, in order to establish criminal liability for an offence in Canada, the standard common law test is expressed in the phrase "*actus reus non facit reum nisi mens sit rea*", or "the act is not culpable unless the mind is guilty" (OHA, 2012). Thus, it must be established beyond a reasonable doubt that a criminal act, or the *actus reus*, has been committed, in combination with a guilty mind, or *mens rea*, as defined by varying degrees required for a guilty mind, but to be indicative of foresight or omission with which a "rational individual" would have understood the act or omission to constitute a crime (Verdun-Jones, 2002).

Thus, philosophically and essentially, an individual can only be found to have been responsible for a crime if they were capable of understanding the nature of their offence and appreciating that it was "wrong", as legally defined. Section 16 of the Criminal Code codifies the verdict of NCRMD as such: "no person is criminally responsible for an act committed or an omission made while suffering from a mental disorder that rendered the person incapable of appreciating the nature and quality of the act or omission or of knowing that it was wrong" (Criminal Code, 1985, s. 16). An individual found NCRMD has been determined to have been unable to appreciate that the action they took was wrong, or worse than a particular other action.

The Supreme Court of Canada has interpreted the term mental disorder as a “disease of the mind” (Verdun-Jones, 2014). A disease of the mind is any illness, disorder or abnormal condition that impairs the human mind and its functioning, but generally, it does not include a self-induced state caused by alcohol or drugs or transitory mental states such as hysteria or concussion, although sometimes a substance-induced psychosis may be found to be a disease of the mind (Verdun-Jones, 2014). In *R. v. Stone (1999)*, the Supreme Court of Canada determined that the issue of a “disease of the mind” was strictly a question of law, and not a medical term per se, while the notion of “wrongness” was both a legal and moral question, that is, it speaks to the moral code of a reasonable individual (Verdun-Jones, 2014). The *Stone (1999)* case elaborates further, stating that “while expert medical evidence is necessarily of considerable relevance in determining whether a particular mental condition should be classified as a disease of the mind, the ultimate decision is for the trial judge, who must take into account issues of public policy such as the safety of the public” (Verdun-Jones, 2014). Importantly, by defining the test for disease of the mind as a question of law, but the test for wrongness as a question of morality, both the criminal justice system and the psychiatric system become philosophically and legally entwined, as psychiatry is provided remit over the disciplines of considered conduct and rationality (Rose, 2000a; Murray & Burgess, 2014). Ultimately, in determining whether to reach a verdict of NCRMD, the court will look to the expert evidence of a forensic psychiatrist, usually by way of a written assessment report, which is intended to assist the court in determining whether or not the accused suffered from a mental disorder at the time of the offence such that the NCRMD defence would be applicable (OHA, 2012).

In 1992, Canada wholly reformed sections of the Criminal Code through Bill C-30 to accommodate individuals raising a defence of NCRMD (Grantham, 2014; OHA, 2012). Prior to

1992, mentally disordered accused raising a defence of “not guilty by reason of insanity” (NGRI) were automatically and indefinitely institutionalized. As a result of a landmark case in *R. v. Swain (1991)*, the Supreme Court of Canada determined that essential changes to the Criminal Code and its treatment of individuals suffering from a mental disorder were necessitated by violations of the Canadian Charter of Rights and Freedoms as a result of the nature of detention surrounding NGRI cases (Grantham, 2014; OHA, 2012). Specifically, sections 7 and 9 of the Charter were offended as the liberty interests of the accused were violated due to their being automatically detained without procedural protections and detention was arbitrarily determined by a lack of specific criteria to determine whether such detention was warranted.

Importantly, the *R. v. Swain (1991)* case brought about the creation of provincial review boards through Bill C-30, and codified under section XX.1 of the Criminal Code of Canada (Verdun-Jones, 2014). Review boards are quasi-judicial organizations that have jurisdiction over accused individuals found NCRMD. Each province and territory is mandated to establish a review board to oversee individuals who are NCRMD, referred to as “accused”. Review boards are legislated to make dispositions on the supervision orders for individuals found NCRMD. The review boards are traditionally made up of up to five individuals. At least one member of the board must be qualified to practice psychiatry, and in the event there is only one such member, there is a requirement to have an additional member who has “training and experience in the field of mental health and is entitled to practice medicine or psychology” (OHA, 2012). The board must minimally consist of a chairperson, a psychiatrist, and any other member with interest in the case; often times this will be a social worker or hospital staff overseeing the accused (OHA, 2012).

Section 672.54 of the *Criminal Code* provides for the types of dispositions that may be made by the review boards in respect of NCRMD accused (OHA, 2012; Criminal Code, 1985, s. 672.54). This section also lists the four factors that a review board must consider in determining which of the possible dispositions should be made, requiring that the review board make the disposition that is the “least onerous and least restrictive” to the accused. The four factors are:

1. The need to protect the public from dangerous persons;
2. The mental condition of the accused;
3. The reintegration of the accused into society; and
4. The other needs of the accused.

Of interest here, is that the review board must consider the “mental condition of the accused” at the time of the disposition hearing, rather than their mental disorder considered at the time of the index offence – the concept of “mental condition” connotes a broader understanding of the accused’s faculties than does the more restrictive mental disorder used in determining a verdict of NCRMD at trial. Mental condition has not been strictly defined and is left to the evaluation of the members of the review board to determine the potential risk to the safety of the public in discharging an NCRMD accused individual based on such a condition (Verdun-Jones, 2014).

Evaluating the factors to consider in making a disposition decision, there are two essential elements underlying the philosophy and mandate of the review boards. Rendering a disposition requires that the review board first protect the safety of the public, and then safeguard the rights and freedoms of mentally disordered individuals under their auspices. Furthermore, they are mandated to “determine levels of risk” in making disposition decisions for NCRMD accused (ORB Mandate, 2009). While the twin pillars undergirding section 672.1 of the Criminal

Code are the protection of the public and treating mentally disordered accused with fairness and fundamental rights accorded by due process, there is a fundamental primacy of the safety of the public written into the legislation of the review boards that ensures an actuarial design of conduct and procedures (*Mazzei v. British Columbia*, 2006; Broderick, 2006).

Three possible dispositions are available to NCRMD accused across cascading levels of risk, based on whether or not the accused poses a significant threat to the safety of the public: an Absolute Discharge, a Conditional Discharge or a Detention Order (OHA, 2012). As stated in section 672.54 of the Criminal Code:

Where a court or Review Board makes a disposition...it shall, taking into consideration the need to protect the public from dangerous persons, the mental condition of the accused, the reintegration of the accused into society and the other needs of the accused, make one of the following dispositions that is the least onerous and least restrictive to the accused, with a majority vote by the board members determining the disposition to be made:

1. Where a verdict of not criminally responsible on account of mental disorder has been rendered in respect of the accused, and in the opinion of the court or Review Board, the accused is not a significant threat to the safety of the public, by order, direct that the accused be discharged absolutely;
2. By order, direct that the accused be discharged subject to such conditions as the court or Review Board considers appropriate; or
3. By order, direct that the accused be detained in custody in a hospital, subject to such conditions as the court or Review Board considers appropriate.

Absolute Discharge

In order to be granted an absolute discharge, the review board must be satisfied that the “accused is not a significant threat to the safety of the public”. If an accused is not positively found to be a significant threat to the safety of the public and is therefore to be absolutely discharged, the review board will have no further jurisdiction over the accused. In making a determination, the review board must consider as stated, first and foremost, the future risk to the public in determining the issue of significant threat.

Conditional Discharge

A conditional discharge is made in the case where an accused is considered a significant threat to the safety of the public but can be managed in the community. The accused is allowed to live in the community subject to various conditions set out in the disposition order. These conditions typically involve consistent reporting to a hospital, refraining from substance abuse, agreeing to regular urine and blood tests, and various conduct restrictions (OHA, 2012).

Detention Order

Where the review board determines an individual represents a significant threat to the safety of the public and they are unable to be monitored in the community, they must order a person detained in a forensic psychiatric hospital. Detention orders include various conditions surrounding the level of security of the hospital, the authority of the hospital staff, and the treatment plans of the accused, as well as outline any potential privileges including access to the community and community resources (e.g. as part of a treatment plan) (OHA, 2012). Such conditions are generally left to the discretion and authority of the lead hospital staff overseeing the detained accused.

Significant Threat

In another landmark 1999 decision in *Winko v British Columbia (Forensic Psychiatric Institute)*, the Supreme Court of Canada defined the test for determining what is meant by a significant threat, stating “it is a real risk of physical or psychological harm to members of the public...that goes beyond the merely trivial or annoying. The conduct giving rise to the harm must be criminal in nature” (OHA, 2012). The Supreme Court also wrote that “there is no presumption that the accused poses a significant threat to the safety of the public. Restrictions on his or her liberty can only be justified if, at the time of the hearing, the evidence before the Review Board shows that the accused actually constitutes such a threat...if the Board cannot come to a decision with any certainty, then it has not found that the accused poses a significant threat to the safety of the public” (Grantham, 2014).

Significantly, it is legislated and established that there is no presumption that the accused poses a significant threat to the public, thus it is not for the accused to prove a lack of dangerousness; rather it is to the review board in an inquisitorial approach to identify the level of risk posed by the accused. The review board has an obligation to evaluate all available evidence relevant to the four factors to be considered in making a disposition. In support of this inquisitorial approach, the review board will look to the hospital where the accused has been detained for evidence relative to the accused’s mental condition (OHA, 2012). Pertaining to the issue of significant threat, the hospital report is essential insofar as it will outline the use of any formal risk assessments that predict the potential for future recidivism, as well as reports of the accused’s most recent conduct. Additionally, according to the *Winko 1999* decision, the review boards can and should consider a broad range of evidence including (OHA, 2012):

- The past and expected course of treatment for the accused;

- The accused's present mental condition at the time of the hearing, including the presence or absence of symptoms of mental disorder;
- The accused's insight into the relationship between the mental disorder and the index offence, as well as the need for medication;
- The accused's plans for the future, and their feasibility;
- Available community support for the accused;
- The accused's criminal history and the gravity of the index offence; and/or
- The health care teams' assessment of the accused, including the clinical risk assessment.

The review boards have no legislated power to force treatment on an NCRMD accused save for very limited occasions, thus the accused must give their consent to treatment. While coercive treatment is supposedly legislated against, there is a clear expectation that medication compliance and treatment will play an integral role in an accused ultimately being absolutely discharged (OHA, 2012; Broderick, 2006).

Bill C-14

As stated in the introduction, recent amendments to the Criminal Code and the NCRMD defense specifically, indicate an apparently harsher turn for the criminal justice system and its treatment of NCRMD accused individuals. The legislative reforms received royal assent under Bill C-14 “An Act to Amend the Criminal Code and the National Defence Act (mental disorder)” (Bill C-14, 2014). The summary for Bill C-14 states “this enactment amends the mental disorder regime in the Criminal Code and the National Defence Act to specify that the paramount consideration in the decision-making process is the safety of the public and to create a scheme for finding that certain persons who have been found not criminally responsible on account of mental disorder are high-risk accused” (Bill C-14, 2014, p. 2).

Essentially, the reforms incorporate much of what had already been established through case law in the previous regime into legislation. Parliament amended subsection 672.54, altering the necessary requirements for rendering a disposition by replacing the previous requirement that a disposition be the “least onerous and least restrictive”, with the requirement that a disposition be “necessary and appropriate in the circumstances” (Bill C-14, 2014). Furthermore, under subsection 672.64(1) of the Criminal Code, a new “high-risk accused” designation has been added, allowing for a prosecutor to apply to have a superior court, not the review board, designate an NCRMD accused as a high-risk offender if they were found NCRMD due to a serious personal injury offence and were 18 years of age or older at the time of the offence (Bill C-14, 2014). If an accused is designated high-risk, then the review board has no choice but to order a detention order in a forensic hospital. Subsequently, under section 672.81(1.32), a review board may extend the time for holding a disposition review hearing from the standard 12 months to up to 36 months (Bill C-14, 2014). A third amendment was made via an additional subsection to section 672.54, essentially codifying what was stated in *Winko (1999)* and other case law, stating that “a significant threat is a significant risk to physical or psychological well-being...resulting from conduct that is criminal in nature but not necessarily violent” (Bill C-14, 2014; Grantham, 2014).

Opponents of this new regime have stated that extreme cases involving mentally disordered individuals committing serious violent crimes, as well as an attendant lack of public understanding regarding the current review board scheme, have allowed for this push towards a more punitive NCRMD regime, under the auspices of increased public safety and victim’s rights (Grantham, 2014). Stated outright and by implication, opponents to the new reforms have suggested that the prior formulation of the NCRMD legislation was fair and balanced, while the

new reforms are punitive and scrupulously unfair and unnecessary (Dempsey, 2014). The most recent reforms, however, essentially codify prior case law and precedence, albeit with a new high-risk designation for NCRMD accused, although this is determined by the prosecutor and trial judge, not left to the review boards themselves. Additionally, a recent Ontario Court of Appeal decision has held that the terms “necessary and appropriate” as written in Bill C-14 in fact continue to mean the “least onerous and least restrictive” to the accused individual, and that the prevailing jurisprudence on that standard continues to apply (*Ontario ORB v. Ranieri*, 2015, para. 20-21).

The importance of this perceived major distinction in legislation is that previous policy that is almost entirely intact is held up as emancipatory. Essentially, however, it is mandated for review boards, past and present, to err on the side of caution in making a disposition decision to avoid political and professional backlash at the release of a recidivist accused (Curtis, 2015; Konrad, 2016; Rose, 1998). Furthermore, both Crown and the accused are represented at the review board hearings, and while the approach is said to be inquisitorial, it is in the interest of the Crown to protect the safety of the public. Thus, the Crown will typically emphasize the severity of the index offense and the hospital reports as *prima facie* evidence of the potential risk posed by the accused (OHA, 2012; Verdun-Jones, 2014). Prior research suggests that while the process is supposedly inquisitorial, in practice the accused is often kept silent as defense counsel tries to “protect them from themselves” or their testimony is left to the end of the hearing, rarely having much chance to weigh in on their own disposition (Livingston, Crocker, Nicholls & Seto, 2016).

The majority of the NCRMD legislation that remained untouched by Bill C-14 is problematic in its wording, insofar as once an individual is adjudicated as NCRMD, the legislation broadens the scope and powers of the review boards to consider a looser determining

factor, the notion of mental condition of the accused rather than disease of the mind, as well as a more extensive but potentially erroneous pool of evidentiary sources to make a determination. As risk is for the most part aggravated rather than mitigated by an individual's circumstances (i.e., the so-called reasonable individual has a baseline level of risk above zero that will simply be aggravated by dispersion from the normative mean), the potential disposition decisions become more circumscribed in their actual application (Hannah-Moffat, 2005; 2006). The legislation suggests significant harm must be constituted by a criminal behaviour and be associated with a real risk of physical or psychological harm to members of the public. It fails, however, to delineate an actual level of severity required of a criminal offence, opening the door for all codified offences, including nuisance ones, ultimately negating the presumed protection against onerous dispositions afforded by such a provision.

Similarly, the criminal justice system has not commented on the definition of what constitutes a "real risk of physical or psychological harm", such that the notion of psychological harm could constitute any of the myriad behaviours deemed problematic and counterproductive to a larger social ethos (Szasz, 2003; Rose, 2000ab). Moreover, an NCRMD accused can only be granted an absolute discharge where the review board is satisfied that the accused is not a significant threat to the safety of the public. Thus, while the four factor model for determining dispositions does not explicitly relate a primacy of the level of significant harm posed by the accused, the ultimate disposition will bear upon such an assessment, with the remaining factors determining the level of restriction required after the possible nullification of an absolute discharge. Furthermore, in *Mazzei v. British Columbia (Director of Adult Forensic Psychiatric Services)* (2006), the Supreme Court of Canada held that the main objective of part XX.1 of the Criminal Code was the protection of the public and the management of the accused's safety risk.

The National NCRMD Population and Ontario Review Board at a Glance

The Ontario review board presents as a systemic middle ground between British Columbia and Quebec – the three provinces with the vast majority of NCRMD cases (approximately 90% of NCRMD cases fall within these three provinces), as well as being the three most populous provinces in Canada, representing 75% of the Canadian population (Crocker et al., 2015d; Statistics Canada, 2016).

In terms of the forensic systems in each province, Quebec has one provincial psychiatric hospital, as well as over 50 mental health institutions that can support NCMRD accused people. These mental health institutions are not specifically meant for forensic psychiatric patients, making interagency communication around forensic psychiatric patients and training more limited than in British Columbia and Ontario (Crocker et al., 2015d). In British Columbia, the British Columbia Forensic Psychiatric Services Commission coordinates clinical care services for all NCRMD individuals across the province in either the British Columbia Forensic Psychiatric Hospital or through one of six regional clinics (Crocker, et al., 2015d). Finally, in Ontario, the forensic mental health system operates in a middle ground between the more highly structured orientation of the British Columbia services and the more diffuse and independent organization of services in Quebec. In Ontario, people found NCRMD are treated and managed in one of 10 forensic facilities. These operate independently, but interagency communication is organized through a Forensic Directors Group to coordinate clinical services across the province (Crocker et al., 2015d).

In terms of absolute numbers, NCRDM verdicts are only a fraction of total criminal offence cases, estimated at less than 1% of adult criminal code offences (Gulayets, 2016). In terms of NCRMD verdicts generally, Quebec produces a much higher proportion of NCRMD

verdicts than British Columbia or Ontario, however all three provinces have low rates in absolute terms. In Quebec, 0.93% of criminal court cases result in an NCRMD verdict, while in British Columbia and Ontario, 0.08% and 0.11% of criminal court cases result in an NCRMD verdict, respectively (Crocker et al., 2015a).

The Ontario Review Board is identified as being particularly onerous, especially at the outset of an individual's trajectory through the NCRMD process. Nationally, initial dispositions resulted in 44% of cases being detention orders, 37% of cases being conditional release orders, and 19% of cases being absolute discharge orders (Crocker et al., 2015a). In contrast, Ontario cases resulted in 77% detention dispositions, and 13% and 10% conditional discharges and absolute discharges, respectively. Therefore, on average, 33% more cases in Ontario result in a detention order at the initial disposition than in the national population.

As a population, NCRMD individuals were charged with a violent index offence in 8% of cases. Furthermore, 72.4% percent of people had at least one prior psychiatric hospitalization in a review of over 1800 cases from Quebec, British Columbia and Ontario, while less than half had no prior contact with the criminal justice system before the index offence (Crocker et al., 2015b). These data suggest that the majority of individuals found NCRMD had prior, direct contact with a given provincial mental health system, and in many cases this was several contacts, before being charged with their defining index offence. This index offence, subsequently, tended not to be severely violent (e.g. homicides or sexual offences).

Indeed, 80% of Ontario cases involved an individual having been diagnosed with a psychotic spectrum disorder, and 14% of cases involved an individual having been diagnosed with a mood spectrum disorder (Crocker et al., 2015b). In general, individuals found NCRMD in Canada are likely to be single, unemployed males in their mid 30s, with some history of

involvement in the criminal justice and psychiatric systems (Gulayets, 2016; Crocker et al., 2015cdb). Importantly, despite the surface appearance of a homogenous population, there exists distinct variability in the particular diagnosed disorders, the actual index offence, the socio-economic and living situations, and the criminal and psychiatric histories of individuals found NCRMD, as well as the availability of various provincial forensic services by area.

Literature Review

Ultimately, irrespective of the recent changes to the NCRMD legislation, the NCRMD legislation has essentially remained unchanged. There is myopia to the critiques of the potential for increased punitiveness in Bill C-14 that ignores the largely unaffected foundation of current NCRMD legislation. In a genealogical sense, it is useful to analyze the historical praxis of review boards in order to determine the potential significance of these more recent changes for the disposition of NCRMD accused in the present and future (Crowley, 2009).

The following section is a review of the literature on judicial and tribunal decision-making, legal evidentiary standards, and quantitative and qualitative research on the subject of mental health review boards. The literature review serves both to provide the current project with an appropriate foundation on which to perform an analysis and to indicate any gaps in the current literature that might be filled by the study (Berg, 2009; Marshal & Rossman, 1999). Finally, a review of the literature can help to focus the research question and locate it with respect to similar research (Marshall & Rossmam, 1999).

In reviewing the literature on legal and mental health tribunal decision-making in general, there are indeed several studies regarding judge and jury decision-making (*sensu lato*) with respect to expert witnesses and their evidence (for example: Cramer, Brodsky, & DeCoster, 2009; Porter, ten Brinke, & Gustaw, 2010; Brodsky, Neal, Cramer, & Ziemke, 2009; Boccaccini, Murrie, Clark, & Cornell, 2008; Kraus & Sales, 2001; Casper, Benedict, & Perry, 1989). As review boards consist primarily of an acting judge and a psychiatrist who are tasked with evaluating an abundance of evidence from psychiatric, medical and lay actors, the notion of expert witness testimony and the assessment of expert evidence is an important consideration for conceptualizing how a panel might justify a particular disposition. A passage in the *Winko*

decision outlines the evidence to be taken into consideration by a review board and references psychiatric experts directly, stating “the inquiries conducted by the Court or Review Board are necessarily broad. They will closely examine a range of evidence...perhaps most importantly, the recommendation provided by experts who have examined the NCR accused” (1999, para. 61). Justice McLachlin also essentially stated in *Winko* that the review boards function relatively autonomously due to their expertise in medical, legal and social factors: “Its members have special expertise in evaluating fully the relevant medical, legal and social factors which may be present in a case. If the court or Review Board, after reviewing all the relevant material, cannot or does not conclude that the NCR accused poses a significant threat to public safety, it must order an absolute discharge” (*Winko*, 1999, para. 55). Clearly the panel must all evaluate the hospital report and psychiatric assessment at a minimum in order to understand the nature of the accused’s recent conduct and their treatment compliance, as indicative of their apparent rehabilitation efforts.

It is evident that criminal court judges make judgments as to the applicability and utility of certain domains of scientific knowledge regardless of their legal admissibility, preferring medical-biological (Viljoan, Roesch, Ogloff, & Zapf, 2003) and clinical opinion evidence over research papers and actuarial evidence (Goldstein, Thomson, Redding, & Osman; 2003; Redding, Floyd, & Hawk; 2001; Krauss & Sales, 2001). In one specific example from Viljoan et al.’s (2003) study analyzing how judges have resorted to drawing on aspects of an expert witness’ character and credibility, rather than the probative value of the evidence presented, they present the case of *R v. F.D.M* (1987). The defendant’s sanity was in question, and a psychiatrist and psychologist gave slightly differing, but related diagnoses. The judge in this case stated in his rationale for decision, “who are we to believe and whose testimony are we to accept – the

psychologist or the psychiatrist? In my view, the only one qualified to testify is the psychiatrist” (Viljoan et al, 2003, p. 372). Thus, a particular preference for certain forms of evidence and those presenting it appear to be present in the legal framework undergirding the review board system.

Based on this preliminary review of research, however, and despite the growing body of literature on the interplay between mental health tribunals and the criminal justice system, there remains an identifiable dearth of research in terms of documented justifications for evidentiary credibility in determining risk for mentally disordered accused (Heise, 2003; Rowland & Carp, 1996; Langevoort, 1998). As Bybee (2012) observes, legal and sociological scholars tend to search for the so-called “true” sources of judicial action, arguing that beyond judicial explanations lie judicial attitudes, strategies, and politicized priorities influencing decision-making. There remains a lack of investigation, however, into the formalized justifications for particular decisions as systemic accounts of what is deemed useful in a particular case or process. As Hutton (2006) suggests, disposition decisions do not necessarily reflect a ‘real’ account of what the judiciary are attempting to accomplish, or what they truly thought, rather it is simply a version of events that might be analyzed to distinguish it from alternate accounts.

Glancy and Bradford (2007) describe the most pertinent legal precedents that help inform contemporary research and Canadian court decisions on the admissibility of scientific expert evidence. While the review boards are quasi-judicial inquisitorial tribunals, they must still call on various pieces of evidence and consider almost exclusively expert witness evidence in the form of hospital staff reporting on the conduct of the accused in hospital. The Supreme Court of Canada case of *R. v. Mohan (1994)* outlined four criteria for the admissibility of expert evidence generally, based on its: legal relevance or probative value versus its prejudicial effect; its

necessity in assisting the trier of fact with understanding all relevant facts of the case; the absence of any exculpatory rule that would have normally required the evidence to be presented; and delivery by a properly qualified expert, based on whatever credentials or criteria are determined by the court and the professional authority overseeing the expert witness (Glancy & Bradford, 2007). The *Daubert* test, based on the 1993 American case *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, requires that scientific evidence be evaluated against four factors: whether the scientific technique can and has been tested in the scientific community; whether the technique has been subjected to peer review and publication; the potential rate of error and; whether the theory or technique used has been generally accepted by the scientific community in terms of scientific journals and knowledge-bases. Importantly, the *Daubert* case defines and expands the gatekeeping role of the judiciary, stating that judges must adequately scrutinize and evaluate the scientific evidence proffered, before admitting it into evidence. Finally, in *R. v. J-L.J. (2000)*, the Supreme Court of Canada established the test for novel scientific evidence, which essentially combines the *Daubert* and *Mohan* tests for any scientific evidence that does not have an established history or precedent in the court. Thus, the legal system is faced with evaluating evidence not only from an accepted legal standpoint but from an accepted scientific standpoint, as prescribed in the *Daubert* and *J-L.J.* tests. As members of the mental health review board include judges and psychiatrists, it is important to understand the legislative rule for determining proffered scientific evidence. With respect to review boards, however, the process is inquisitorial such that the judiciary can compel any evidence deemed relevant to the case, such that the member judges and psychiatrists will be tasked with evaluating various pieces of scientific evidence for its clinical and legal validity and reliability.

Dixon and Gill (2002) found in a review of 399 federal district court opinions that the *Daubert* test appeared to promote greater scrutiny of the reliability, relevance and qualifications of expert evidence. Judges seem to be following the Supreme Court decision in determining the admissibility of expert evidence by critically reviewing the techniques and methods underlying the production of evidence. Dixon and Gill (2002) do well to note, however, that their research does little to explain how well judges are performing their gatekeeping duties. The fact that the judges are apparently reviewing expert evidence with greater scrutiny does not necessarily assume that this scrutiny is appropriate or sound, either from a legal standpoint or a scientific standpoint.

Further, Edmond (2008) theorized that legally-accepted reliability and validity measures are insufficient, and indeed, many triers of fact, judges included, are unable to adequately assess reliability from an established scientific standpoint. The Kaufman Inquiry regarding Guy Paul Morin's wrongful conviction suggested that the actors in the court system are susceptible to manipulation via the sociolegal construction of the evidence presented (Kaufman, 1997). The inquiry helped illuminate the vulnerability of the court to the legitimizing effect of expert evidence. One crown counsel said "We, Crown or defence, can become victims of the experts" (Kaufman, 1997, p. 251). A committee report for the working group on the prevention of miscarriages of justice also noted that as an increasingly diverse field of scientific disciplines such as biomedical psychiatry find their place in the judicial system, judges are faced with the need to educate themselves on fundamental science in order to critically evaluate the evidence presented to them (Report on Miscarriages of Justice, 2004). It is becoming increasingly difficult for triers of fact to evaluate the reliability and admissibility of varied and novel scientific evidence (Hans, 2007). Moreover, Edmond (2008) posits that indeed measures and

assumptions regarding reliability and validity in terms of scientific knowledge are socially constructed, dynamic processes, affected by time and place. Thus, Edmond (2008) suggests that it is important to establish criteria for admissibility of evidence based on a demonstrable reliability, rather than previously accepted notions of scientific and forensic techniques. Edmond fails to address, however, how this shift towards establishing a demonstrable reliability will better address the problem of socially instituted regimes of knowledge and truth on expert evidence, and the attendant issue of the judiciary having to scrutinize apparently scientific evidence from a largely unknowledgeable legal standpoint.

Gatowski et al.'s (2001) study on state court judges found that judges endorse the role of legal gatekeeper, but lacked the scientific knowledge necessitated by the *Daubert standard* to scrutinize and assess expert evidence. They found judges more often than not accepted the majority of evidence presented as “scientific” under a view of general acceptance. Gatowski et al. (2001) concluded that judges shared little consensus on what actually constituted “scientific” evidence, and subsequently have trouble operationalizing the criteria from the *Daubert* decision. These findings suggest that judges tend to base their decisions on dominant discourses and knowledge systems, considered in a common sense fashion as more or less “scientific”.

Gulayets (2016) conducted a study to identify differences between those raising the NCRMD defence successfully and those ultimately found guilty. The research project looked at 138 individuals in a remand facility for forensic patients, and identified the most salient factor differentiating successful NCRMD defences from unsuccessful guilty verdicts as psychiatric opinion given as evidence, either in terms of diagnosis of a psychotic disorder or in terms of recommendations by a psychiatrist through court-ordered assessment reports (Gulayets, 2016). Thus, the impact of psychiatric opinion in court is seen to be an important element in judicial

decision-making. Indeed, an American study conducted by Steadman, Keitner, Braff, and Arvanites (1983) demonstrated a concordance rate between psychiatric opinion and verdict of over 90%. In a Canadian study by Ohayon, St-Onge, Caulet & Crocker (1998), the researchers found a concordance rate between psychiatrist recommendations and the court verdict of 76% for successful NCRMD verdicts, and 85% concordance for unsuccessful NCRMD verdicts, or guilty verdicts. Gulayets (2016) notes that a high correlation between expert witness recommendations and case outcome does not establish a causal relation between verdicts and psychiatric opinion. It does, however, identify an apparently increasing influence of forensic psychiatric discourse on the legal decision-making process.

Discourse in this sense can be considered in light of a Foucauldian conception of discourse that is not so concerned with the specific syntactic and linguistic properties of rhetoric and discourse (Hamilton & Roper, 2006). For Foucault, discourse conceptualizes phenomena through the dissemination of knowledge claims. These knowledge claims subsequently render phenomena intelligible in light of the dominant discourse defining such things in the first place (Foucault, 1982; Hamilton & Roper, 2006).

Thus, there is an attendant dearth of research into how review boards are constituting and governing the accused in framing their decisions while negotiating the issues of criminal responsibility and risk at the juncture of legal and clinical systems of knowledge (Klassen, 2016; Curtis, 2015; Langevoort, 1998). In terms of prior research into the decision-making process of mental health review boards, as well as mental health tribunals internationally, there is similarly a lack of investigation into the particular decisions made by the review board. Rather, researchers tend to take a more directed approach, statistically analyzing the specific risk factor terms that appear in various decisions as evidence of a preference for legal or clinical criteria, or offering a

broad picture of the NCRMD population as a whole (Broderick, 2006; Crocker et al., 2015abcd; Charette et al., 2015; Nichols et al., 2015).

The extant research into the decision-making process of Canadian mental health review boards has tended to focus on quantitative analyses of factors correlated with particular disposition decisions (see for example Curtis, 2015; Grant, 1997; Balachandra et al., 2004; Desmarais, Hucker, Brink, & De Freitas, 2008). Research has also tended to focus on the impact of the landmark *Winko* decision on the propensity and procedure for making certain dispositions. Likely accounted for by the fact that the *Winko* decision was based in British Columbia, the majority of research focusing on the decision-making process of provincial review boards in Canada since 1999 has relied on the British Columbia review board and its cases through 2005, with a select few studies focusing on Quebec and/or Ontario; these three review boards comprise the vast majority of the NCRMD population (Crocker et al., 2015bd; Broderick, 2006; Curtis, 2015; Balachandra et al., 2004; Salem, 2015). While the conceptualization of mental health review boards is legislated federally under the Criminal Code of Canada, each provincial review board is legislated in practice at the provincial level. Therefore each review board differs in the sense that they have their own provincial mental health policy, provincial political culture, and programs underlying the decision-making praxis, treatment policy options and forensic and community mental health support structures available. Thus, generalizability and lateral comparisons across provincial samples is limited.

In fact, the National Trajectory Project, funded by the Mental Health Commission of Canada, offered a population study of NCRMD accused that examined the operations of the mental health review boards in Quebec, Ontario and British Columbia from 2000 to 2005, with an additional three-year follow-up review of each of the 1800 cases under study (Crocker et al.,

2015abcd; Charette et al., 2015; Nichols et al., 2015). In this study, the researchers found that Ontario was significantly more onerous in its decision-making than the other two provinces. For example, Ontario was found to have the highest agreement between hospital recommendations and disposition decisions at 92% agreement between all cases, with an attendant higher presence of hospital representatives and psychiatrists at their hearings (Crocker et al., 2015a). The presence of lay individuals, including the accused, is significantly lower than in the other provinces, indicating a particular regimentation present in the Ontario review board system (Crocker et al., 2015a). Additionally, Ontario had significantly longer retention rates for individuals under supervision than the other provinces, indicating that from initial detention, it takes significantly longer to receive an absolute discharge. For example, five years following an initial detention in custody order, 79% of individuals in Ontario were still in custody, while 47% and 23% were still in custody in British Columbia and Quebec, respectively (Crocker, et al., 2015a). Ultimately, the National Trajectory Project found through a regression analysis that the number of prior offences, having a diagnosed psychotic disorder at verdict, and being under the purview of the Ontario Review Board all decreased the probability of a conditional or absolute discharge for individuals found NCRMD nationally (Crocker, et al., 2015a).

A similar study conducted by Simpson, Penney, and Seto (2014), analyzed population data for NCRMD accused in Ontario over a 25 year period from 1987-2012. The authors analyzed 3, 957 cases admitted to the Ontario Review Board (ORB) in order to assess the rates of admission to the ORB and the demand for forensic psychiatric services over the previous 25 years. The authors noted the importance of documenting potential factors related to the observed increase in rates of NCRMD admissions in Ontario forensic psychiatric institutions in order to identify space for policy adjustments. The number of individuals under the purview of the ORB

has risen approximately 9% every year since the 1990s, resulting in economic and forensic and community service delivery concerns in terms of managing this increasing population.

Ultimately the authors identified two periods of significant surges in population growth amongst ORB admissions: one from 1992-1996, following changes to the NCRMD legislation and enactment of the Review Board system in 1992, and another from 2001-2007, following the 1999 *Winko* decision. In terms of progression through the Review Board system, Simpson, Penney, and Seto (2014) found that in general those coming under the purview of the ORB between 2000-2005 had the fastest rates of absolute discharge, while those between 2006-2012 showed an intermediate rate of absolute discharge (the period between 1987-1992 saw the slowest rate of discharge, before the current MHRB framework was in place).

These two studies contributed valuable longitudinal analyses of cohorts of NCRMD accused, offering a detailed overview of the trajectory of provincial populations, and some broad statistics on the heterogeneity of the NCRMD population as a whole. The characteristic heterogeneous mental health review board populations described in prior research suggest the need for an attendant flexible decision-making process by the review boards, avoiding check-list style decisions while weighing important contextual, individual and historical factors in order to determine dispositions. These prior studies do not offer much in the way of detailed analyses of the particular decision-making praxis of the boards themselves, making this connection difficult to determine while suggesting the salience of the current research project.

An example of research at the level of rationale for decisions indicative of the extant analyses in this area of Canadian mental health review boards was, however, undertaken by Broderick (2006), analyzing the decision-making process of the British Columbia review board for differences in disposition decisions pre- and post-*Winko*. In conducting the analysis,

Broderick (2006) used a mixed-methods approach, analyzing the risk factors correlated with the three possible dispositions through a quantitative content analysis of particular terms, as well as face-to-face interviews with judicial and clinical members of the review board. In this and similar studies (Curtis, 2015; Desmarais et al., 2008; Peay, 1989), researchers identified particular terms that tended to be associated with disposition decisions, including the notions of insight, compliance, actuarial risk/threat, and substance abuse, which have apparently increased in use post-*Winko*. Furthermore, in conducting face-to-face interviews with clinical and legal members of the review board, Broderick (2006) found that they tended to hold differing opinions regarding what is meant by a significant threat, as well as which factors (clinical or legal) are most salient in constructing a risk profile. Hutton (2006) suggests, however, that research into decision-making that seeks to identify a ‘real’ account of the process is mistaken. Rather, asking a judge or decision maker to describe their decision-making would not necessarily elicit an account of how judges make their decisions, but rather simply an account of how they respond to such a question from researchers (Hutton, 2006). Thus, judges’ accounts of how they arrive at their decisions will differ from the venue of the court room, to the anonymity afforded by a researcher, to how they describe their decisions in their private lives to colleagues, for example (Flicker, 2004).

Ultimately, Broderick’s (2006) analysis of the decision-making process of the review board is understood within a therapeutic jurisprudential background, suggesting that once NCRMD accused are absolutely discharged, they lack the necessary support services to maintain treatment compliance and may “fall through the cracks” of the mental health system (2006, p.1). Therapeutic jurisprudence, as a discipline of study, understands the legal system as potentially helpful or harmful to those over whom it has remit (Feeley & Simon, 1992). Ultimately,

therapeutic jurisprudential research seeks to advocate for increased awareness of the potential to offer apparently helpful interventions to those under the auspices of the criminal justice system, as well as other social control systems (Feeley & Simon, 1992). Szasz (2004), typically at the extreme end of a considered libertarianism, contends that therapeutic jurisprudence, rather than being a study of law and prudentialism, is a “(...) study of the perversion of justice and law. The practice of therapeutic jurisprudence epitomizes the ethics of *primum nocere* – harming patients but defining it as helping them” (p. 2). Szasz argues that framing psychiatric and legal management of behaviour as therapeutic obfuscates the potential harm, victimization and subjugation of the individuals under its purview, reifying systems of control and normalization under a lens of treatment over punishment, and patienthood over victimhood (2004).

Regardless of the theoretical background of the research, Broderick (2006) offers a cogent analysis of the particular terms tending to manifest in the rationale for decision. Nevertheless, in conducting a quantitative analysis of risk factors associated with dispositions, the research was prevented from offering an analysis as to why such factors and terms might be consistently present, or how these factors are deployed and understood as meaningful discourse in the evaluation of conduct and mental capacity.

Some salient international studies have conducted more qualitative, constructionist research in jurisdictions offering comparable mental health and criminal justice legislation in the United Kingdom (Peay, 1989), New Zealand (Diesfeld & McKenna, 2005), and Australia (Diesfeld & Sjostrom, 2007), as well as Canadian examples of research into Community Treatment Orders (Klassen, 2016), and one study of NCRMD participant views and experiences in Quebec, Ontario and British Columbia (Livingston et al., 2016). Common throughout this research is the understanding that particular terms – insight, compliance, illness, risk and threat,

among others – tend to present themselves in the majority of decisions regarding individuals regarded as dangerous on account of an ascribed mental disorder. These various studies do well to note a consistent lack of operationalization of these terms. In this sense, the present research will be instrumental in providing one such analysis of the Ontario Mental Health Review Board in the hopes of contributing an interpretation of the discursive conceptualization and deployment of the notion of risk and related terms presented in the rationale for decision.

Theoretical Outline

The purpose of the following section is to situate the theoretical background of this paper in analyzing the development and practice of the Ontario Review Board, exploring ways in which it has come to operationalize the notion of public safety and risk in making dispositions. To understand the relevant legal conceptions of judicial decision-making applicable to a mental health tribunal, a brief review of the legal philosophy underpinning judicial decision-making is presented. This is followed by an introduction to the notion of systems and their interactions through communication or discourse and its relevance to a universal conceptualization of risk.

In order to frame how risk and mental disorder have been conceptualized and deployed, a description of the political ideological notion of neoliberalism and the conceptual framework of governmentality will then be presented, followed by a discussion of the notion of governance through risk. Subsequently, the paper will describe a brief history of forensic psychiatry, as its remit over individuals considered disordered shifts from the strict boundaries of the asylum to the diffuse locale of the community, generating new forms of expertise and new ways in which psychiatry is deployed in relation to other institutions. The supposition is that it will be possible to locate forensic psychiatry as discipline and practice and accorded the role of determining risk in NCRMD disposition decisions within this particular understanding of risk and behaviour, such that a particular way of negotiating risk, mental disorder, and those subjects of mental disorder, will be identified against, aligned or within the legal system.

Two Pictures of Judicial Decision-Making

Judicial decision-making has seen historical shifts in its underlying philosophy in terms of how the judiciary relate to a given case, previous cases, evidence, and conceptions of justice and morality (Butler, 2002). In the classical picture of judicial decision-making, based on a legal

realism, legal decision-making is concerned with the popular notions of precedence, case-based understandings of law, and the universal quality of legal facts (Butler, 2002). In this way, classical legalism assumes that the essence of a legal decision is, and can be, effectively summarized in the published reasons for decisions. These particular reasons form a casebook, wherein a distilled precedent can be analyzed in future cases considered similar to the current case. Classical legalism is defined by a three-step process wherein legal decision-making is based on a similarity between cases; then the precedent developed in the previous case is identified; then the precedent is applied to the current case (Levi, 1949). Implicitly, legal decision-making is seen as a purely factual process whereby similarities and differences between individual cases and prior case law can be applied readily by a judiciary in a broad sense. Thus, classical legalism depicts a system of decision-making that is rationalistic and at once universal and insular. It is in this way that judicial decision-making can be understood and the purpose and rationale behind publishing legal decisions.

In contrast to the classical picture of judicial decision-making, legal pragmatism is critical of the conception of a judiciary that is universally rational and singularly focused on legal facts, current and past. Essentially, legal pragmatism suggests that all decision-making is only contextually relevant. Therefore, reviewing legal cases absent their particular contingencies distorts understanding. Where classical legalism emphasizes the notion of precedent and internal and historical coherence, legal pragmatists emphasize the primacy of consequences in interpretation for future cases and more broadly for worldly consequences of a given decision.

As an extension to a specific legal pragmatism, Richard Rorty presents a broader pragmatic anti-foundationalism that seeks to identify alternatives to current social practice. However, it is not until their consequences are discovered that their ultimate justification as

“useful” can be identified, based on their performance capabilities (Rorty, 1992). Rorty claims that metaphysical entities like truth or reality “are not warrants for certitude” (Baker, 1992: 703). Rather, he suggests that truth is not found in theory, but rather is determined in practice (Weaver, 1992: 731). Thus, for Rorty, there is no universal truth or “real” way of being that a judiciary can lay claim to; judging a practice or belief can only be done “by comparison...by offering alternatives to the way we presently do things” (Weaver, 1992: 757). While Rorty suggests that social realities are a product of contingencies, it just so happens certain vocabularies and social practices developed but these are scarcely the only ones available. We are simultaneously constituted by these current practices such that we have a certain ethnocentrism in how we conceive of the world (Huang, 1994: 505). Rorty suggests that once we realize that we cannot completely rid ourselves of old practices, it will illuminate how we can gradually substitute some new beliefs for the old ones (Huang, 1994: 505). Therefore, we can chip away at the seemingly immutable foundation of given social practices by offering alternative practices. Ultimately, for Rorty, the only method for continued social progress is “courageous and imaginative experimentation” (Baker, 1992: 699).

Rorty is not entirely against a modernist attempt to systematize and categorize phenomenon through objectivity and reason. He elucidates how the philosophical discourse of representationalism or rationalism is merely contingent and thus replaceable (Weaver, 1992: 739). As Weaver suggests: “Rorty’s point is not that representationalism is always bad or never useful, but when it fails we need to move on to some other way of speaking” (1992: 739). In this way, Rorty identifies a key aspect of his pragmatism – that it can accommodate any number of seemingly incommensurable discourses, and this is possible through the notion of localized knowledge and contextual social practices (Weaver, 1992: 745). In this way, Rorty simply offers

“a” way of doing things, that is focused on the particularities of that situation, rather than a universalist and unconditional practice, in contrast to a classical picture of legal decision-making that is universal and insular.

Ultimately, a theory of legal pragmatism can help to situate current conceptions of risk discourse as contextual and contingent on formal understandings of behaviour, rationality, reason and social control. Given an identified heterogeneous population of individuals found NCRMD and the seeming incommensurability of legal discourse as applied to the purported irrationality of mental disorder, a pragmatic understanding of legal decision-making can contribute to new ways of considering the notion of risk and responsibility.

A Tale of Two Systems

In the previous sections there has been mention of a particular interaction between the biopsychiatric and legal systems. This interaction can occur at an overt level, for example in the sense that a forensic psychiatric system has developed to proffer expert evidence regarding criminal responsibility in criminal court cases and mental health review board hearings, as well as the requirements set out in the *Daubert* standards for evaluating expert witness evidence.

Some authors (Conrad & Barker, 2010; Teubner, 1989; Szasz, 2006a) have suggested there is an insoluble tension between a system based on legal conceptions of normativity and one based on a medical normativity in legal and medical institutions. Others, however, have suggested that forensic psychiatry, as a biomedical discipline, engages in a particular reciprocity with the legal system insofar as offenders of the law are implicated by perceived failure of responsibility and rationality of the mind, rather than simply behavioural infractions under the law (Szasz, 2006a; Dailaire, McCubbin, Morin & Cohen, 2000; Hamilton & Roper, 2006).

As legal proceedings become imbued more and more by notions of science and empiricism, the relative weight placed on so-called expert systems of knowledge in the adjudicative process has increased (Faigman & Monohan, 2005; Hans, 2007; Report on Miscarriages of Justice, 2004; Dixon & Gill, 2002; Sanders, Diamond, & Vidmar, 2002). Legal discourse and mental health discourse tend to inform one another, as when legal policy and regulation structures the application of mental health treatment and confinement on one hand, while on the other hand, research into mental health and psychiatric science has implications for the proposed notion of criminal responsibility in the justice system. Rather than a taken for granted relationship, Teubner (1989) highlights the explicit and implicit processes that underlie this relationship between social discourses and suggests that law itself creates its own social reality with respect to knowledge. Teubner (1989) suggests, however, that legal discourse is caught between its dependence on and independence from other social discourses in forming its communicative structure.

Merlino, Murray and Richardson (2008) reiterate the sociolegal construction of a “legal science”, wherein the negotiated movement of proffered scientific evidence to admissible scientific evidence is mediated by the social constructions and deconstructions of the court actors. Notably, the exchange between the legal discipline and a forensic biomedical psychiatric discipline has given greater prominence to the notions of individual risk, safety and conduct through a legal-evaluative framework (Dixon & Gill, 2002; Viljoan et al., 2003). Indeed, Szasz (2006a) suggests that “medicine and law are independent but intimately interacting social institutions. Medicine guards its autonomy jealously and relates to the legal system as an equal partner. Psychiatry, in contrast, submits slavishly to being dominated by the law and obediently meets its demands. (para. 1)”

Of particular significance for analyzing these interactions is the juncture of policy and praxis, and the ways in which system actors tend to produce and reproduce particular discursive ideologies in their coordinated efforts within those systems. The significance of the relationship between the criminal justice system and the mental health system is particularly salient with regard to individuals found NCRMD. An act that is criminal in nature has been committed, and thus would be a question of legal or not legal, but also the offender has been determined to have been unable to appreciate that the offence committed was wrong due to a mental incapacity, and thus no crime has technically been committed, but necessitating the involvement of the psychiatric system. Confounding the situation is that the legal system has adopted through precedence in case law notions of scientific reliability and validity, such that proffered scientific evidence must be scrutinized from an established, though constructed, scientific standpoint, as well as a legal one. Similarly, the legal system has established its own notion of a definition of mental disorder. Thus, two systems are seen to have apparently established an ideologically universal or shared discourse for evaluating particular sets of behaviours around the notions of responsibility, rational action and productivity, as exemplified by current notions of mental health/illness as used in the judicial system.

Neoliberalism and Governmentality

Neoliberalism is a political and economic ideology associated with a move away from welfarist economic and social policies toward a more privatized economic liberalism (Hamann, 2009; Rose, 1993). Where the welfare state focused on state-centered governance and the imputation of state-managed programs, neoliberalism focuses on the privatization of industry and the free market, whereby community-centered private organizations have remit over social programming (O'Malley, 2009; Miller & Rose, 1990). Private organizations and community

agencies enter into quasi-contractual relationships with the state and other private agencies to deliver services seen as more cost-efficient than in welfare economics.

Additionally, neoliberalism depends on the notion of a natural state of affairs, a status quo as part of an obdurate reality (O'Malley, 2009). In this way, neoliberal technologies can intervene when the state (as a system) senses irregularities or dispersion from normality, in order to protect the contingencies of productivity, efficient labour and profit. A key ideological premise then is the notion of self-agency in the community and individually, to enact management in terms of behaviour, economic productivity and risk (Rose, 1998). The state, as a directed form of government, is kept at arm's length, more responsible with outlining and coordinating the limits of potential behaviour of social bodies than with explicitly managing them within those limits. In other words, neoliberalism is seen to promote freedom of choice and action by defining the potential risks inherent in deviant, and subsequently medicalized, behaviour but promoting self-agency within those purportedly natural boundaries. O'Malley (2009) suggests that in a neoliberal form of governance, social institutions such as the criminal justice and mental health systems are outsourced, through competitive tendering, to privatized agencies in the community in order to inculcate a personalized risk management model. Thus the community and private industry are afforded greater responsibility over the care and management of so-called disordered populations and risk in general (Murray & Burgess, 2014).

Neoliberalism as a political and economic ideology exists under the umbra of the broader notion of governmentality, or the rationalities and technologies that make the ordering of populations intelligible and deployable through power relations (Foucault, 1979a). The application of control and management of populations is made possible through varying forms of governance. At its essence, governance encompasses the ways in which citizens are rendered

orderly through policies, techniques of control, rationalities and systems of knowledge that circumscribe the political and social realities of a given community (Rose, O'Malley, & Valverde, 2006; Rose, 2000a). Government, in this sense, is not solely the notion of the State Government as a political entity, rather it concerns the control and management of conduct – the conduct of conduct (Rose, 1998). It is the rhizomatic network of institutions, organizations and the like that confer explanatory power over conduct and behaviour. Knowledge constitutes, and is constituted by, relationships of power insofar as it elucidates particular ways of thinking about phenomena and the ways that individuals govern behaviour based on that knowledge (Foucault, 1982; Rose et al., 2006). As phenomena become conceptualized as natural or intrinsic things amenable to explanation, calculation, categorization and intervention, a particular regime of truth around these conceptualizations develops along with an attendant system of knowledge and those experts purporting to know and understand that system (Rose, 2001).

Governmentality and neoliberalism are less about a state as political entity and its social ramifications, than about the management of conduct as a whole spread across a networked series of institutions – public and private – that purport to know and understand behaviour at an intrinsic level, and thus self-ascribe their remit over particular domains of truth and knowledge, and procedures for administering them.

For Foucault, freedom is defined against a background of risk, such that control is the signpost of freedom in governing conduct (Foucault, 1979b). Freedom and control are not counterweighted in systems of neoliberal governance, rather they define one another. The principal form of conduct management is through systems of knowledge and expertise – economic, political, legal, or psychiatric disciplines that define productive and appropriate conduct in light of a political economy of behaviour (Rose, 1998; Miller & Rose, 1990).

Historically, western democracy developed away from feudal-autocratic forms of state government, where disciplinary power through law and regulation was imposed on subjects, toward a more subliminal form of government concerned with a citizenry of autonomous individuals with civil rights codified under state legislation (Rose, 1998; 2001). Rather than imposing particular forms of behaviour through private and state agencies, certain forms of knowledge reify understandings of what it means to be free, thus inculcating these understandings into the population as a whole, rendering it governable from within. Freedom is thus a network of social representations through which control is exercised and rendered possible. The citizenry then comes to be defined as rational actors who are expected to act responsibly within an economy of conduct (Miller & Rose, 1990). Economy in this context does not refer to a strictly financial sense, but to the prevailing notions of well-being and productive behaviour. It is within this environment that psychiatry as a discipline of conduct, as experts of the mind and mentalities of a population, come to be essential in the workings of the criminal justice system.

Thus, a second key ideological premise for neoliberal governance is the notion of responsibilization (Rose, 1998). In order to successfully reduce the overt micromanaging of populations through law, religion and bureaucracy tendered by the government, neoliberal rationalities responsibilize subjects through the supposedly natural manifestation of risks (Hannah-Moffat, 2005; Murray & Burgess, 2014). In order to delimit its scope, neoliberalism represents particular phenomena as risks – disease, illness, poverty, unemployment and criminality are defined as issues to be avoided by individual self-management and agency in order to ensure a productive social body. Thus, the responsibility to stay healthy, to remain employed and productive in society becomes a particular goal in the project of the self for the

actualizing individual, rather than something forced by the government (Rose, 2001). Through particular campaigns and systems of knowledge, experts are provided an integral role in the transformation of the self. Wealth managers, psy-experts, and experts of the body and health, advertising particular ways of being healthy physically, economically and mentally, are marketed as goods and services in a free market. People are prompted to take control of the risks they face and manage themselves in light of a larger ideology of ethical behaviour defined by expert systems of knowledge. In this way, personal goals and the project of actualization are aligned with political goals for the governance of individuals, reifying the concordance of neoliberalism as governance (Cruikshank, 1993).

It is in this state of affairs, where individuals are tasked with their own actuarial management in hopes of achieving some level of transcendence of the self in light of socio-political goals, that biomedical psychiatry, as a discipline of human conduct and a system of knowledge and experts who have access to that knowledge, can form as it does. Mental illness exists in a constitutive relationship with society – it is untenable beyond the confines of the notion of reason and rationality (Rose, 1991b). Diverse political, social, economic, ethical and philosophical issues are rendered intelligible by the notion of mental illness (Rose, 1991b; Cruikshank, 1993). The discipline and ideological foundation of psychiatry is buttressed by these issues as it forms a particular field of interest for rendering these things relevant and amenable to understanding, calculation, assessment and intervention. A psychiatric subject, once displaced from the auspices of an institution (asylum, forensic hospital), is now defined by “failures of the management of the self, lack of skills of coping with family, with work, with money, with housing...all criteria for qualification as a psychiatric subject...Level of risk has become the key criterion for intervention” (Rose, 1996, p. 14).

Risk as Governance

As described above, the concept of risk is essential to governance in neoliberalism. It is through conferring a specific risk discourse that the boundaries of human conduct are established based on a purportedly natural formulation. Discourse here is considered in the way that Foucault describes it, not in the broader sense used for the study of semantics and linguistics in discourse analysis (Hamilton & Roper, 2006). Foucault posits discourse as referring to sets of knowledge that legitimate particular ways of behaving and explaining behaviour in society (Foucault, 1988a). Indeed, Foucault (1988a) states:

“My objective for more than twenty five years has been to sketch out a history of the different ways in our culture that humans develop knowledge about themselves: economics, biology, psychiatry, medicine and penology. The main point is not to accept this knowledge at face value but to analyze these so-called sciences as very specific ‘truth games’ related to specific techniques human beings use to understand themselves” (pp. 17-18).

Thus, it is through particular discursive means, particular systems of knowledge, that the ideas of risk and significant harm are constituted by mental disorder in the review board system. The production of truth, categories and phenomena as measurable and rendered intelligible occurs through particular discourses (Hamilton & Roper, 2006; Lupton, 1993). According to Lupton (1993), definitions of risk are:

(...) hegemonic conceptual tools that can serve to maintain the power structure of society...Risk communication, whether it is made by government, industry, or other bodies, can readily be regarded as a top down justification exercise in which experts

attempt to educate an apparently misguided public into the real world of probability and hazard. (1993, p. 432)

Individuals are ultimately responsabilized, along with institutions, with mitigating risk where and when possible through particular behaviours. Economic risks can be addressed through forced retirement planning, financial advice, and government sponsored savings. In terms of health, risk can be mitigated through physical health ad campaigns, gym memberships, and the notions of healthism and nutritionism as commodities to be bought and sold in the hope of avoiding disease and illness. In terms of mental health, continuous observance and development of self-esteem in light of normative ideals, as well as medication compliance and an intimate relationship with biopsychiatric therapeutics, is essential to ward off possible mental illness in the first place, and manage it if/when it develops as part of a larger psychiatric project (Rose, 2001; Cruikshank, 1993).

The nature and operation of the notion of risk has changed significantly over time with the advent of Modernity and the Enlightenment (Lupton, 1993; Burr, 2015). In the pre-modern period, prior to the 16th and 17th centuries, the idea of risk was tied into the ideas of religion, fate and destiny, thus unpredictable in a probative sense (Lupton, 1993; Burr, 2015). The meaning of risk has transformed over the course of the last three to four hundred years to include ideas of environmental risks (floods, earthquakes), and man-made risks (industrial pollution, chemical spills, ozone depletion, wars), to more relational risks (financial, criminal, or health-related) (Lupton, 1993). Across early, classical, and late Modernity, and through the emergence of the Enlightenment in the 1700s, the conceptualization of risk transformed in accordance with a positivist scientific method proposing to be able to observe, quantify and ultimately predict natural phenomena, including the prediction of risk based on factors purported to be causally

related to it (Lupton, 1993; Burr, 2015). In this “natural state”, risk is considered neutral, referring to probability or the mathematical prediction of an event, which could be either positive or negative (Rose, 1991a). Risk in this sense is synonymous with likelihood or probability. Over time, what constitutes risk differs across culture and discipline, now generally understood to refer to an undesirable outcome, or the notion of danger, based on a series of foreseeable acts or omissions (Douglas, 1990). Douglas (1990, p. 4) argued that risk is preferred over the notion of danger because danger appears too emotive or evaluative; risk is sterilized, appearing scientific and objective. Similarly, Dallaire et al. (2000) suggest that at the interface of psychiatry and criminal justice, the notion of dangerousness becomes synonymous with mental disorder, thus mental disorder itself is seen as a vehicle through which danger and risk are made amenable to control and management.

Rose (1998) conceptualizes the transformation of the notion of danger into risk in a similar fashion. Rose suggests that there has long been an association between danger and so-called madness, and similarly an association between those considered dangerous as implicitly suffering from madness. There is a shift occurring, however, in how this linkage between madness and danger is understood. Historically, a shift away from depictions of danger towards the language of risk occurred on a large scale over the last 50 years or so, beginning in earnest in the 1980s and 1990s (Rose, 1998). Dangerousness thus became associated with a constellation of factors, rather than strictly a dichotomy on individual grounds, to be diagnosed and treated as a means in and of itself.

Snowden (1997, p. 32) asserts that “it is debatable whether the notion of dangerousness now has any utilitarian value for psychiatry...dangerousness is nothing more than an adjective which has been elevated into a pseudoscientific construct whose definitions amount to little more

than past harm predicts future behaviour”. Implied, subsequently, is that the notion of risk has such a utilitarian value for psychiatry as a whole, and forensic psychiatry specifically. This particular shift in constructs and thought gained traction in part due to apparent concerns over the protection of civil rights in battling against involuntary and arbitrary detention of those suffering from mental illness, and the inability of forensic psychiatry to appropriately predict danger as a criterion for release (Dallaire et al., 2000). Risk, on the other hand, offers a constellation of proscriptions and prescriptions of behaviour meant to mitigate the possible harm of possible future behaviour.

Conventional research into the notion of risk in the criminal justice and mental health systems tends to focus primarily on the development and application of actuarial risk assessment tools (Hannah-Moffat, 2005). These tools are used to quantify, calculate and ultimately intervene in the mitigation of risk through identification of particular static (historical and unchangeable, like a history of drug use, criminal history, or history of mental illness) and dynamic (fluid and changeable, like current drug use, occupation, education, and personal associations) risk factors (Garland, 2001; Hannah-Moffat, 2005; Bonta & Andrews, 2007).

In critical risk scholarship, however, risk and dangerousness are considered through the lens of governance and governmentality as a product of the normalization of behaviour: risk relates to what is considered abnormal, a threat to specific normative behaviour and standards of living (Szasz, 2006b; Rose, 1998; Hannah-Moffat, 2005). Beck (1992), for example, suggests we have entered a total risk society, a society that looks at risk homogenously as the end-game concern of governance. What is problematic with Beck’s description of a risk society is that it attempts to provide an understanding of concerns, techniques and processes for managing and identifying risk that are assumed to coalesce into a homogeneous entity. Risk strategies and risk

management, however, are heterogeneous insofar as their vocabularies and actions differ across clinical, environmental, epidemiological, actuarial, forensic, probabilistic, monetary, and political factors and disciplines (Hacking, 1991; Lupton, 1993). Risk thinking has emerged within specific problem fields, in relation to specific systems of expert knowledge, and specific consequences for those managing risk and those being managed by risk, that is to say technologies of the control of ethics have emerged for psychiatry as a whole. Rose (1998, p. 181) states that “risk thinking, in a paradoxical move...recognizes the impossibility of certainty about the future, simultaneously making this lack of certainty quantifiable in terms of probability...Once one has quantified the probability of a future event occurring, decisions can be made and justified about what to do in the present.”

Another theory of risk, presented by Feeley and Simon (1992) as describing the emergence of a new penology, contends that a new form of governance has established itself. The new penology is less concerned by responsibility, fault, diagnosis or treatment of the individual. Rather it is concerned with wholesale classification and management of homogenous groups based on levels of risk at the level of criminal justice (Feeley & Simon, 1992). The focus is thus on risk management, rather than responding at an individual level. Castel (as cited in Rabinow, 1982) said regarding psychiatry that management and control are deployed at a macro level, away from pathologies and treatment; instead control strategies attempt to reduce risk by anticipating “possible loci of dangerous irruptions through the identification of sites statistically locatable in relation to norms and means” (p. 243).

Importantly, rather than existing exclusively, the new penology can be understood as an extension of other forms of control and intervention, such that management of criminal behaviour and by extension mental illness and the role of forensic psychiatry is extended, rather

than reordered. Rose (2010) states “probabilistic and actuarial styles of thought have supplemented and reshaped clinical and legal thinking, but they have not replaced them. Risk strategies may seek actuarially to reduce the risk to public safety of populations, but they do so by seeking to identify, classify and if possible neutralize riskiness of the individual” (p. 215). In this, strategies of risk management are understood as a combination of risk strategies, a hybrid formation where risk is wedded to varying entailments within and around the individual and community.

A Brief History of Psychiatry

Neoliberal society sees a particular transmutation of forensic psychiatry underlying the current model of mental health review boards and the political management of marginalized populations across systems defining social order and the ethics of behaviour. Of significance here is the turn toward deinstitutionalization over the backdrop of a community responsibilized with mitigating its own risks. This particular state of affairs is seen to create space for a legitimated psychiatric field in conjunction with the legal system for the social ordering of behaviour based on an emancipatory language of autonomy, rehabilitation and freedom of action through a return to community living.

Psychiatry is only possible as a discipline of human conduct through a system of relations structured around a series of experts, deviations in conduct they purport to know and understand, and judgments on the proper way of responding to such conduct (Rose, 1998). In this way, a particular field of interest is delineated around a commonality of representation and intervention for behaviours deemed problematic by a larger socio-political ethos, and legitimated through a medicalization of such behaviour (Rose, 2000b).

The term medicalization is used to describe a process by which certain problems become defined as medical issues, to be studied, cured or treated via the medical establishment (Ost, 2010). The process of medicalization is related to the construction of undesirability of particular conditions or problematic behaviour in popular thinking and or public policy (Ost, 2010; Conrad & Barker, 2010). Through medicalization, these newly defined conditions, brought within the purview of medicine, involve certain forms of treatment decisions emanating from and dispensed by qualified health professionals who, “by virtue of their training and expertise, are insofar as treatment is concerned enjoined to stand superior to those they treat” (Ost, 2010, p. 4). In this the idea of medicalization is closely tied in with the distribution of power and control over certain populations. In contemporary literature, the semantic distinction between the terms “disease” and “illness” is often cited as the natural presentation of impairment in physical body functioning, against the stigma and experiences associated with the socially constructed notion of illness (Conrad & Barker, 2010). Critics argue, however, that the differentiation of the terms is problematic since diseases themselves are rendered intelligible and defined as such through certain ways of testing and investigating for so-called impairments in bodily functioning (Conrad & Barker, 2010). The critique is extended towards biomedical psychiatry, where the focus is on impairments in mental functioning, with attempts to correlate particular neurological, chemical or physiological presentations in the brain with conduct labelled as abnormal.

Kawa and Giordano (2012) have studied the historicity of biomedical psychiatry and the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most influential professional text and resource for reference to the characterization and diagnosis of mental disorders in North American psychiatric practice. They note that over time the DSM has gone through a process of medicalizing, de-medicalizing, and now re-medicalizing behaviours defined as disorders due to

the advent of particular political pushes and new technologies toward more objective understandings of mental disorder (Kawa & Giordano, 2012). A particular manifestation of the medicalization and classification of behaviours as disordered can be located in the DSM. In 1952 the first DSM was released, defining 106 disorders. Within 60 years, the number of diagnoses has increased by over 300% to 365 disorders in the latest iteration of the manual, the DSM 5 in 2013 (Cosgrove, Krinsky, Vijayaraghavan, & Schneider, 2006). Kawa and Giordano (2012) highlight the fact that the DSM calls for the inclusion of biological data, behavioural genetics, and psychopharmaceuticals in the identification and treatment of disorders. The DSM fails, however, to specify how neurochemical, neuroimaging and other biological data studies should be used and interpreted in establishing diagnoses of mental disorders. Thus, the medicalization of disorders is meant to legitimate and objectify the constructs defined by biopsychiatry, but it is unclear exactly how these particular regimes of knowledge are being used and whether or not they provide reasons for such justifications (Kawa & Giordano, 2012; Rose, 2000b).

On the opposing side, de-medicalization can be defined as “stripping away medicine as a dominant frame of reference to reveal the “true” nature of the phenomenon” (whatever “true” is...) (Ost, 2010, p. 4). The notion of de-medicalization seeks to strip the province over specific problems from the expert systems claiming control over them. Proponents of de-medicalization argue that medicine itself can be harmful insofar as it places patients at risk of iatrogenic effects, or subsequent social or health problems as a result of the medical intervention they receive. Ost (2010) argues that legal, ethical and social discourses surrounding medicalized problems tend to legitimize and promote the involvement of medicine, thus reifying their initial involvement. Behaviour considered mentally disordered is considered as such based on the very behaviours being used to establish it as disordered, thus representing a form of circular thinking (Sadler,

2009). The symptomatic behaviours come to define and be defined by particular disorders. Biomedical psychiatry has made inroads into neuroscience, biology, and the pharmaceutical industry in order to establish a set of medical assessment tools to identify the potential genesis of disorders that are physically present in the brain and its chemistry (Rose, 2003; 2010). Certain behaviours and social problems are seen to come under the purview of biomedical psychiatry to be treated as medicalized concerns, where they may have been considered differently before. The province over normalized conduct is thus placed in the hands of psychiatric experts. As the criminal justice system is situated to manage individuals seen as problematic in their overt behaviour, their interrelation is unavoidable.

Forensic biopsychiatric institutions developed according to a particular medicalized vocabulary, a system of classification of disorders, diagnoses, taxonomies, nosology and treatments, legitimizing the discipline under an empirical biomedical lens and reconciling a demand for public safety with a constitutional demand for the protection of civil rights (Rose, 2000a; Szasz, 2007). In terms of public safety, there is an expectation that those individuals seeming to live by the ethics of what is considered normative and productive behaviour are kept safe from those failing to conduct themselves appropriately – the economics of productive behaviour must be protected from those defaulting from its constraints (Tarizzo, 2011).

Simultaneously, however, there is an expectation that citizens are afforded particular protections and constitutional rights prohibiting coercive treatment, confinement and the like – a protection of freedom and property, which can only be surpassed by an offense under the law (Szmukler, 2013). Thus, the meeting point between political governance through public safety and civil rights is dynamic in the sense that a medical psychiatric system is capable under the law

of confining individuals deemed at risk to themselves and others, while adjudicating on issues of responsibility and freedom.

The risk of danger posed by NCRMD accused intersects with the notion of mental disorder, such that they come to be interchangeable in the criminal justice system and public forum (Dallaire, McCubbin, Morin, & Cohen, 2000). Politically and as a discipline, psychiatry reifies itself as a legitimated science of human conduct and mental health through connections with general medicine and the criminal justice system – its domain of knowledge and system of experts seen as essential for the coordination of things in the legal system. The appeal to public safety and the risk of harm is central to the development of policy, sentencing and decision-making practices at all levels of the justice system. A transmutation of psychiatry as the legal entity by which confinement and overt behavioural control could be enacted by way of legally mandated coercion under the umbrella of public safety has led to the creation of forensic psychiatric entities (Rose, 2000b). More broadly, however, psychiatry has remit over the very nature of criminal responsibility in the sense of evaluating an individual's risk of recidivism, their personality (disorder), potential psychopathic tendencies, and their particular levels of risk and need, evaluated against offerings of expert guidance to the criminal justice system in the court room, sentencing, prisons, rehabilitation and release (Hannah-Moffat, 2005; Helen, 2011). Forensic psychiatry suffuses a criminal justice system that levies the notion of rehabilitation of its subjects against the underlying goal of protecting the safety and productivity of the public within a medically-legitimated framework.

Psychiatric institutions like the asylum (more recently the forensic hospital) allow for this demarcation both physically and ideologically, underpinning the nosography, categorization and treatment of a range of disorders that were central to the establishment of a positivist medicalized

science of mental illness as discipline and practice. As Rose (1996, p. 7) suggests, “the asylum...institutionalized the boundaries of what we have today come to contemplate as mental illness at the same time as it conferred diagnostic powers and therapeutic authority upon those medical agents who control and organize the space of confinement.” Thus it becomes a system whereby expert systems of knowledge are reified by the very conditions they seek to identify and classify through investigation and classification.

The role of the psychiatrist was further demarcated as not merely a custodian of warehoused individuals, but a technician and expert of social order. The role of the psychiatrist became that of curing a specific diagnosis and restoring an individual to the status of responsabilized and rational citizen, free to conduct themselves within the confines of larger society. In so doing, the psychiatrist is ultimately defining disordered conduct as a transgression of presupposed proper conduct of the self as defined by a larger social ethics of behaviour. Thus, the mentally disordered became representative of threats to public safety, with an exponentially greater number of behaviours and issues being cast under the light of the moral-medical vocabulary of mental illness (Rose, 1996; Helen, 2011). Concurrently, due to a movement towards deinstitutionalization of those previously confined to asylums beginning in the 1960s and continuing in earnest in the 1970s and 1980s, there has been a significant increase in the number of mentally disordered individuals coming under the purview of the criminal justice system in North America, and Canada specifically (Helen, 2011).

Additionally, developing according to a particular medicalized vocabulary, a system of classification of disorders, diagnosis, taxonomies, nosography and treatments, psychiatry reconciled a demand for public safety with a constitutional demand for the protection of civil rights (Helen, 2011; Rose, 1996). In terms of public safety, there is an expectation that those

individuals seeming to live by the ethics of behaviour that are acceptable in a neoliberal society, are kept safe from those failing to conduct themselves appropriately – the economics of productive behaviour must be protected from those defaulting from its constraints. Thus, the meeting point between public safety and civil rights is fluid insofar as a medical psychiatric system is capable under the law of confining individuals deemed at risk to themselves and others.

Ultimately then, over the course of the last 40 to 50 years, the role of psychiatry became intertwined with a series of politico-legal projects for the conduct of individuals across the social sphere, not simply within institutions (Rose, 1998). As the notion of civil rights and public safety become entrenched as two pillars supporting the government of behaviour, it becomes necessary to link the interests of psychiatry to those of other apparatuses similarly governing conduct, such as the criminal justice system and social institutions – schools, occupations, and the family. It is through these connections that the notion of criminality, as a strictly legal entity, becomes the subject of inquiry, as psychiatry makes inroads into the courtroom and the legal system. Cases involving notions of insanity or mental disorder become ensconced in a legal biomedical psychiatric light, in the hope of both identifying problematic behaviour while legitimating confinement based on a boundless evidentiary standard undergirded by a psychiatric discipline capable of defining and evaluating human conduct, and ultimately harnessed by the legal system self-appointed as the ultimate authorities on human conduct (Lupton, 1993; Helen, 2011; Hamilton & Roper, 2006).

Psychiatry becomes a way of rendering intelligible those individuals threatening social order, not necessarily through legal means, but through moral and ethical means. Those seen as unproductive, disordered and distracting to a machinery of society fixated on production and proposed emancipation towards a particular way of conducting themselves under the guiding

notion of freedom of conduct within the neoliberal context. Individuals defaulting from this state of affairs are seen to fall under the auspices of psychiatry, as it lays claim to all forms of behaviour considered deviant (Dallaire et al., 2000). Defining individual pathology as a medical issue, as part of the biology or constitution of individuals, leads to the understanding of entire segments of the population in bio-medical terms (Rose, 2000b). It establishes a new form of understanding and describing behaviour that assimilates the individual in the mental institution with those in society suffering from disorders of constitution disruptive to social and domestic relations due to a lack of ability to cope with whatever miscalculation of behaviour has occurred in the individual (Rose, 2009).

The importance of this shift in ideology is essential for our current understanding and application of the notion of risk within and without the forensic hospital and the mental health review board. As the field of interest of psychiatry broadens away from the confines of the institution and becomes diffuse into the community, it takes on a prophylactic role for governing the conduct of the population before the development of an explicitly dangerous individual. Thus, inefficiencies of any form of conduct, seen as destructive to the machinery of production of society and its larger ethos, are formulated as consequences of mental disorder across a series of categories and spectrums – not necessarily requiring institutionalized treatment, but requiring intervention nonetheless.

Rehabilitative intervention, like culturally-accepted notions such as “self-esteem”, becomes a technology of citizenship, whereby voluntary association to the ideals of the status quo is elicited without the use of force or coercion. Intervention thus becomes a way of identifying, monitoring and managing a multitude of behaviours defined as problematic, or diseased, or criminal, or deviant, whichever suits the area of concern. For example, Murali and

George (2007) describe a preliminary nosology and treatment for internet addiction which is representative of the legitimated domain of scientific psychiatry veiling the need to address and control behaviour that is seen as unproductive or maladaptive. Internet addiction is described as affecting mostly those individuals with impulse control issues and those with low self-esteem, and suggests that a large proportion of individuals neglect important aspects of their lives in using the internet (Murali & George, 2007). Further, some individuals with an internet addiction are characterized as lacking adequate positive reinforcement through “natural reinforcers” such as sex and food, and thus seek “unnatural” reinforcement through the internet. This depiction reasserts the notion of a natural and scientific quality, and implies the need to address the individual’s apathy and lack of self-esteem – and thus reform their identity. The fact that there is no nosological continuity or conceptual validity is largely ignored by the authors, who suggest the need for a prophylactic response to a proposed internet usage problem (Murali & George, 2007). In this way, individuals can begin to micromanage their behaviour before a potential problem is officially defined. Much like the issue of self-esteem and depression, the notion of internet addiction is largely constructed as a problem simply because it is being investigated as such (Cruikshank, 1993).

For intervention to be successful in the eyes of the state there must be change in conduct that suits whatever is defined as appropriate conduct in society. Thus, the self is constituted by notions of ethics and authority, and through its action upon the self, intervention results in the actual and total subjugation of individuals through their own freedom to exercise power.

Psychosocial interventions provide people this illusory sense of control over their own governance and subjectification, while the proliferation of psychosocial problems, such as internet addiction and self-esteem deficiencies, serves to provide increasing opportunities for the

state to widen its net of social control from the public sphere into the private and ultimately psychological/subjective spheres.

Thus the home, school, workplace and the like become arenas for the deployment of psychiatric intervention in the hopes of limiting the potential occurrence of ethically dangerous conduct. A transmutation towards the medicalization of psychiatry and its interests, as well as the attendant support (or cooptation) of general biomedicine, allows for the deployment of psychiatry across a broader area of interest. By deploying new forms of technology for governing conduct at source through prophylaxis rather than as a response to some culminating event, a series of public and private actors are made capable of disseminating psychiatric technologies throughout the community – group homes, half way houses, social workers, private and public psychologists, case-workers, and response teams – and create increased linkage between the medico-psychiatric institution, the courtroom, the school, work and family, under the guiding light of a neoliberalist state of governance.

Implicit in these ideas is the notion that psychiatry can act on the government of conduct across a series of locales. As Rose (1996, p. 12) states regarding the transformation of psychiatry as a particular bounded institution to a more diffuse discipline of social conduct, “psychiatry would reintegrate its disparate aspects into an administrative network which would bring together the diverse subjects with which it dealt”. Psychiatry’s role within this system is less to treat and intervene in the strictest sense, but rather to administer individuals across a networked system of control, to make decisions and dispositions that would determine where along this tract of halfway houses, day centres, hospitals, treatment teams, an individual would be directed.

It is through this particular understanding of the genealogy of psychiatry and the transformation of the citizen-subject into an administrative-actuarial concern, that we can come

to conceive of the role of forensic psychiatry in determining interventions for individuals found NCRMD in the legal system.

Current Research Goals

Forensic psychiatric services are costly and involve a major loss of liberty, thus there are important policy implications for understanding and investigating the legal justification for particular dispositions in NCRMD cases (Desmarais et al., 2008).

This is an important period in time offering fertile ground for research involving detailed analyses into the decision-making praxis of the review boards in order to develop an understanding of discursive conceptualizations of risk and the factors involved in assessing levels of risk. The review board hearing dispositions offer an account of the post-hoc rationalization or justifications relative to decisions made. These officially sanctioned documents offer the justification process and a historicity of the review board at an overt, systemic level. Indeed, existing research has argued that particular changes to Canadian legislation have been a sanctioned response to changes in the direction of the court and/or review boards at a processual level beforehand (Verdun-Jones, 2014; Livingston et al., 2016).

While the recent policy changes have had little time to proffer much in the way that review boards and the criminal justice system are responding, it is important historically to document this change insofar as it makes for the increased salience of analyzing past and present practice in the hope of identifying vectors for policy change and/or knowledge production (Crowley, 2009). Therefore, this paper interrogates the legal rationale by which individuals are discharged or detained, by asking how the review boards reconcile the notion of criminal responsibility and public safety, and legal and clinical factors in their dispositions. The importance of such an understanding is twofold. First, it might indicate the knowledge structures inherently useful to this particular iteration of a legal system legislatively imbued by forensic psychiatric services. Second, it might highlight the rationalization process and room for

development, expansion or transition in this process in practical terms to ensure the ethics and equality of a system dealing with a particularly marginalized population.

In section XX.1 of the Criminal Code, it is legislated that a review board provide a written rationale or reasons for any disposition made within ninety days of the hearing. These reasons outline the official version of the review board's justification for a given decision and choices made within a given case. The review boards and legal process in general are ostensibly objective arenas where triers of fact act as impartial mediators capable of evaluating a diversity of evidence and making a determination based on the social constructions and liberal principles underlying the common law legal system. Importantly, according to a classical realist understanding, the judiciary are unaware of these social constructions, in a broad sense, such that notions of risk, mental condition, capacity, or disorder, and issues of legal admissibility, justice and injustice are taken for granted as natural constructs. Regardless of a trier's actual motives, it is important to investigate what has come to be defined as an acceptable rationale, in terms of a sociolegal context, for members conferring a particular disposition decision.

Disposition decisions do not necessarily reflect a "real" account of what the judiciary are attempting to accomplish, or what they "truly thought". Rather it is simply a version of events that might be analyzed to distinguish it from another account (Hutton, 2006). Indeed, Hutton suggests that research into decision-making that seeks to identify a "real" account of the process is mistaken (Hutton, 2006). In this sense, asking a judge or decision maker to describe their decision-making process might not elicit an account of how judges make their decisions, but simply an account of how they respond to such a question from researchers. Ultimately, Hutton (2006) argues that in order to arrive at any sort of meaningful production of knowledge, we cannot seek to understand unequivocally how decisions work. Research must therefore reconcile

its goals with its methodology, to arrive at the most reasonable and useful way of acquiring knowledge for that particular project. In the case of this project, investigating the justification for decisions made by the Ontario Mental Health Review Board offers an analysis of one point in the genealogy of officially sanctioned reasoning surrounding NCRMD dispositions.

Thus, the rationales for decisions produced by the review boards are an essential historical document in that they represent the officially tendered rationale for the praxis of the review boards. Regardless of the actual motives or underlying factors that may be involved in a particular disposition, the written reasons are what come to constitute a given case at a micro level and the discursive structure and ideology of the review boards at a macro level based on the “official” nature of this document. As Sadler (2005) notes, a discipline or profession does not permit much interpretation or characterization without reference to its texts. Thus policy, legislation and the written reasons represent the closest approximation to a benchmark for the profession (Sadler, 2005). The reasons are used for issues of setting precedence for other hearings and interpreting future cases, and establish the standard language for forensic decisions, diagnostics, research and public understanding of the overt praxis and function of the review boards. Additionally, due to its standard reference status, the written reasons “represent a historical trace of unquestionable importance, carrying a historical-cultural ethos, and most acutely, widespread and direct impact on people’s lives. Moreover, as written text, it possesses a permanence that enables an exegetical rigor that would be impossible when studying the shifting sands of any field as a whole” (Sadler, 2005, p. 6). Thus, the written reasons offer a historically legitimated lens of the officiated praxis of the mental health review boards, illuminating a possible genealogy of procedure and justification for decision-making to inform current and future policy and research.

This research will analyze the praxis of mental health review boards via the rationale for decisions. Ultimately it seeks an understanding of the ways in which forensic psychiatry and the legal system, as a medico-legal discipline, negotiates and accommodates the notions of risk, mental disorder, and public safety in their disposition decisions of NCRMD accused, simultaneously constituting and governing the NCRMD individual as both a subject of risk and a subject of medicine.

The paper will also seek an understanding of how a particular legal system in the form of the mental health review board, buttressed by a forensic biomedical psychiatric system, negotiates and accommodates the notion of risk and mental disorder in its praxis. The juncture of the legal system and the mental health system offers a point of departure for analyzing how conduct is constituted, valued and controlled – both in the institution and in the community. In terms of policy and praxis, it is essential to analyze the taken for granted approach to decision-making tending over those marginal subpopulations occupying a liminal state between dangerousness and responsibility on the one hand, and treatment and care on the other hand, insofar as they are deemed both mentally ill and thus of diminished capacity, and offenders, and thus implicated in a breach of trust and public safety (Crowley, 2009; Hamilton & Roper, 2006; Playle & Keeley, 1998; Murphy & Canales, 2001).

Investigating the construction of risk in the justification process of decision-making from the standpoint of the Board can have ramifications for the role of expert witnesses, particular evidentiary standards, the notion of mental disorder, and the medicalization and deviance of particular behaviours in the legal and correctional systems in terms of policy and practice. What comes to be defined as expert knowledge is filtered through a juridical discursive process in which individual perceptions, evaluative decision-making processes, social representations, and

values impact the ability of particular discourses to address adjudicative questions, which must subsequently be articulated in a rationale for decision. Rather than regard scientific and legal notions of truth and acceptability as inherently credible or not, the instant research is meant to elucidate the discursive structure and knowledge system underpinning the Board's justification process. Sadler (2005) puts the issue succinctly in the following paragraph, stating:

The utterance of a question, or the creation of a category, brings structure to the mind-boggling universe of experience, but the price paid is the loss of 'brimming, bustling confusion' that is the often overwhelming complexity of our lives. Every reduction of experience necessitates a loss of complexity. Trying to figure out mental disorders is confusing in its own right – they are complicated unique conditions. Couldn't we consider psychiatry as a set of answer constraining questions or hypotheses? That is, diagnostic classifications are statements about the status of mental disorders to date, as well as hypothetical entities whose validity is continually being examined. If so, what are the implications? Which evaluative world views are implicitly advocated within such diagnostic constructs? Whose interests are respected or ignored? How should these fundamental questions be decided upon? Who should decide them? (2006, p. 8).

What is argued here is that the very nature of mental illness is constructed on appeals to so-called normative and appropriate behaviour. As such, the decision-making processes used by a judiciary increasingly bound by popular notions of 'scientism' might constitute and orient itself around a circumscribed domain of knowledge with respect to deliberations on mental health issues (Szasz, 2006b; Leising, Rogers, & Ostner, 2009). Practically, the implications of such a juridical system are the increasing marginalization, institutionalization and criminalization of mentally disordered populations and the potential circumvention of civil and liberal principles.

Methodology

Positioning (Epistemology and Ontology)

Positioning in research reflects the underlying ontological and epistemological stance of the observations and interpretations presented in the analyses. Ontology relates to the nature of reality itself, and what can be known about it (Guba & Lincoln, 1994). King and Horrocks (2010) suggest that ontology considers the “assumptions that a particular approach to social enquiry makes about the nature of social reality” (p. 8). In this sense, it becomes clear that methodological decisions are rooted in ontological positioning, insofar as what would count as a relevant area of study will depend entirely on this underlying assumption. Two broad notions of ontology are presented in the form of realist and relativist stances (Kinash, 2012; King & Horrocks, 2010). Broadly, a realist stance suggests there is an objective reality ‘out there’ that can be represented accurately in study, while a relativist stance suggests reality, as a whole, is constructed by the interactions and interpretations of individuals, thus these multiple subjectivities reproduce reality *in situ* (King & Horrocks, 2010; Kinash, 2012). As suggested, methodological commitments cannot be understood in isolation. Thus, determining the ontological commitment will help to understand the subsequent epistemological framework, or the way in which we understand knowledge claims, or the nature of the relationship between the inquirer and what can or cannot be ‘known’ (Subberwal, 2009; Gubba & Lincoln, 1994). Where ontology considers what can be known, epistemology considers how that knowledge is constructed, acquired or understood.

Social constructionism is a relativist conceptual framework that emphasizes the contextual elements of phenomena widely understood to be natural (Conrad & Barker, 2010). The framework emphasizes the construction of meaning through social interaction, examining

how individuals/communities/cultures contribute to producing perceived social reality (Berger & Luckman, 1996). Forensic psychiatry and the medical model assume that diseases or disorders are natural, invariant phenomena that can be ‘discovered’. A social constructionist conceptualization of disease, however, would consider that observable physiological or mental conditions are not so-called natural kinds, or inherently diseases, but rather negotiated contextually as such.

Similarly, Teubner (1989) highlights a constructionist epistemology that underlies the relationship between social discourses and suggests that law itself creates its own social reality with respect to knowledge. This project suggests the socially constructed nature of a legal science is bound by a particular view of the legal and biomedical psychiatric systems that value objectivity and rationality in their discursive procedures and practices. This local, contextual understanding of the legal process suggests that the stated rationale of legal discourse can be taken at face value; however, the underlying communications are open to interpretation (Borland, 1991). Thus, the goal of the project is to gain a deeper understanding and awareness of the Ontario Review Board’s operations in accommodating the constituted irrationality of “mental disorder” within a framework constructed around the notions of rational action, production, risk and a circumscribed domain of medical knowledge.

The epistemological framework, then, is constrained by this view of a context-relevant reality. As a result, interpretation and understanding derived from interacting with the rationales for decision will be a subjective and contextualized interpretation, that does not seek to represent a ‘true’ or ‘natural kind’ of discourse (Carter & Little, 2007). In this way, identifying this interpretive and transactional epistemology leads to a qualitative methodology that seeks not to quantify a relationship between phenomena and suggest that “this is how decisions work”, but

rather to seek a deeper, more nuanced understanding of the legal discourse and its production *in situ* (Labuschagne, 2003).

Qualitative Content Analysis

Carter and Little (2007) suggest that “methods are the praxis that realizes the other elements...it is through methods that methodology and epistemology become visible” (p.1325). It is under this notion that the methodological commitments of the project are situated, as they are commensurable with the overlying epistemological commitments, but sensitive to the constitutive nature of the methods themselves. Methodologically, I conducted a qualitative content analysis, applying it to judicial rationales for decisions in cases involving a defence of Not Criminally Responsible on Account of Mental Disorder.

The debate between the use and fundamental quality of quantitative versus qualitative research methods is longstanding. However, as Onwuegbuzie and Leech (2005) suggest, their similarities may at times exceed their differences, such that they are more complementary than exclusionary practices. The focus on a qualitative methodology for the current project is based on the notion that the choice of quantitative or qualitative methods should be based on the goals and objectives of the research (Sommers, 1997). In quantitative methodologies, the generalized goal is to identify a quantifiable relationship between phenomena with the goal of achieving generalizability and replicability (Onwuegbuzie & Leech, 2005; Guba & Lincoln, 1994; Labuschagne, 2003; Golafshani, 2003). The current project, on the other hand, sought to describe the justification process of the review boards, and offer a nuanced, interpretative understanding of the material. Labuschagne (2003) suggests that qualitative analysis implies “an emphasis on processes and meanings”, which produces deeper and more nuanced data (Labuschagne, 2003:

100; Golafshani, 2003). Thus, the epistemological focus on interpretation and subjectivity lends itself to the application of a qualitative methodology.

Qualitative content analysis (QCA) is an analytical approach that “employs codes to develop internally consistent and externally mutually exclusive categories (manifest level) that are afterwards interpreted in view of finding the underlying meaning reflected in the emergent themes (latent) (Graneheim & Lundman, 2004). Manifest content focuses on the surface structure presented in a text, while latent content is the deeper structural or thematic understanding conveyed by the message. It is beneficial to understand both manifest and latent content as they contextually define one another. Berg has suggested that in conducting qualitative analysis, it is important to start by simply reading the sample data to get a feel for it, and then re-reading it, immersing yourself in the data in order to identify particular content, themes and subthemes (Berg, 2009).

Essentially, it is a qualitative analytical method that deconstructs the data under study into particular themes based on the text itself, and then undertakes to interrogate those themes in order to identify particular overlying interpretations. For example, in a given rationale for decision, there may be mention that the accused “lacks insight” and is therefore a significant risk to the safety of the public. In order to interrogate the concept of insight and its connection with risk, QCA would seek to situate the ways in which insight is used discursively to define risk and what it means to be risky in relation to the context of the texts under study.

Content analysis is broadly defined as “identifying, categorizing, and analyzing specific words, phrases, concepts, or other observable semantic data in a text or body of texts with the aim of uncovering some underlying thematic or rhetorical pattern running through these texts” (Huckin, 2004, p.14). In order to undertake a content analysis it is important to identify the units

of analysis, as well as conceptualize the coding process (Babbie, 2008). Identifying the unit of analysis will inform sampling decisions, as the unit of analysis is what is under study (Babbie, 2008; Huckin, 2004). The current project sought to identify particular themes in the individual words and phrases of the texts, such that it went beyond the simple manifest meaning of the words, or the superficial meaning of a given word, and identified their latent or underlying meaning and discursive structure, based on the contextualized nature of the words themselves in the text (Babbie, 2008). Conceptualizing the coding process involves defining the main features to be identified, in this case, particular exchanges between expert knowledge systems in law and psychiatry in defining a risk profile of an individual found NCRMD.

Furthermore, this research was concerned with investigating the discursive content underlying the justifications proffered by the Board in constructing the rationales for decision, rather than actively identifying a direct relationship between the terms and factors presented. Berg (2009) suggests that the basis for qualitative content analysis is found in avoiding this claim to causal relations between terms and phenomena. While the heart of content analysis is a “coding operation and data interpreting process” (Berg, 2009, p. 339), it is rudimentary to merely identify manifest meaning in the discourse, thus a deeper investigation is required to meet the goals of the research.

Braun and Clarke (2006) suggest that content analysis operates at the micro level. As identified, the objective of the current project is to go beyond quantification. It suggests that a clear, predictable relationship cannot appear, and further it includes both a micro-analytic approach in identifying individual words and phrases, while combining it with a macro-level analysis that consolidates the relationship between forensic psychiatry and its praxis. Qualitative Content Analysis can be seen as a foundational method for content analysis, as it offers a flexible

and broad method for identifying patterns in qualitative material that can undergird more systematic analysis, while avoiding simply quantifying data sets (Braun & Clarke, 2006; Attride-Stirling, 2001).

Sample Data Collection

This study employed a qualitative content analysis, analyzing a purposive sample of published rationales from disposition hearings of Not Criminally Responsible on Account of Mental Disorder cases from the Ontario Mental Health Review Board from January 1, 2004 to July 10, 2014, the day before bill C-14 gained royal assent. This period was chosen to give the most recent 10 year sample, taking into account legal precedence, the gap in analyses in Ontario, as well as in cases post-2005 generally, while avoiding overlap with previous research investigating the effect of the *Swain* and *Winko* cases, respectively.

Qualitative research tends to require only a sample that allows the researcher to identify consistent themes which would indicate relative saturation in the data. Thus, purposive sampling, a non-random sampling method that allows the researcher to make an informed decision as to what data to select, is considered acceptable because it can be used to select specific cases that will offer the most fruitful textual analysis, as opposed to the random selection of material. In this study, cases were specifically chosen from the period identified, and only those cases that indicated there was dissention within the Board in their decision-making. Dissention occurs when the Board does not unanimously agree on particular elements of the disposition – these can range from disagreeing on the primary issue of risk of significant harm to the public, to issues of particular conditions or understandings of evidence presented. Therefore, dissent on its own does not necessarily describe total disagreement, but it suggests the presence of ambiguity or stress

within the Board. Such stress may lead to the emergence of less circumscribed or more subjectively-relevant rationales in justifying the decisions that were made.

Thirty cases, 15 resulting in detention dispositions and 15 resulting in absolute discharges were selected across a ten year period from January 1, 2004 to July 10, 2014, the day before Bill C-14 gained royal assent. The sampling procedure is based on the notion that for grounded theory research, Creswell (2002) suggests 15-20 participants. There is a lack of sampling guidelines for qualitative research as a whole (Leech, 2005), however the similarity between grounded theory methodology and qualitative content analyses (they seek secondary and tertiary levels of abstraction, albeit with different goals) lends itself to a similar sampling scheme. Ultimately the goal is to acquire enough cases so that the research can reach a point of saturation in terms of themes, where no new or major themes and ideas are emerging from the data.

While each province's review board is legislated federally under the Criminal Code of Canada, they differ in the sense that they have their own provincial mental health policy, provincial political culture, and programs underlying the decision-making praxis, treatment policy options and forensic and community mental health support structure. Thus, it is reasonable to assume that lateral comparisons across provincial samples might be limited. Furthermore, British Columbia cases may have reached a point of saturation while Ontario and Quebec samples are comparatively understudied, hence the focus on the Ontario review board in the present research. Additionally, as mentioned in the *Introduction* and *Review Board System in Canada* sections, the Ontario Review Board has been identified through prior research as being particularly onerous, employing stringent practices involving the highest degree of professional presence, lowest degree of lay-person presence, and longest rates for individual detention periods. The forensic psychiatric system itself has also be located at a middle ground between a

closely networked system unified under one organization (as in British Columbia) and a loosely coordinated network of institutions tangentially related through various organizations (as in Quebec).

In any review board disposition hearing, the judiciary must make a determination and present their rationale for such a decision, drawing on elements of the case and the evidence presented. The phenomena under study are these text-based legal decisions, in the form of transcribed narratives from the review board panel members.

In the interest of situational validity, which suggests documenting how the data were derived in the first place (Chenail, 1995), a search was performed in the LexisNexis Quicklaw directory of Canadian legal cases. Selecting for Administrative Boards & Tribunals, and the Ontario Review Board (Criminal Code) Decisions, a search was conducted to randomly select cases from the period between 2004 and 2014, using keywords “not criminally responsible” and “dissent*” to include cases involving dissenting opinions, and “absolute” or “detention” to identify absolute discharges or detention orders. Random selection was performed by listing all available cases by absolute or detention in an excel spreadsheet, and applying a random number generator to the two lists. The first fifteen cases identified in each list were chosen for inclusion. These cases were further screened to ensure they were actually absolute discharges or detention orders, in the event that these terms were present in the case but not actually relevant to the present disposition. From there, the included links for the selected cases were followed to the written decisions, where they were downloaded as text files to be analyzed.

Information Processing and Analysis

The stages of QCA essentially require a broad reading of all of the text, making notes and jottings of the relevant terms and themes appearing in the data. Then, through subsequent, closer

readings, more themes and further condensing of the subject matter occurs, until such time as no new themes are emerging and the study reaches saturation. Hsieh and Shannon (2005) have indicated that around ten categories is sufficient to allow for a large amount of text to be sorted based on the themes, while avoiding coding each term as a new theme or category.

The actual material processing occurred by hand, with a systematic reading and coding of the material. The analysis in effect ran part and parcel with processing the material, as it is throughout the categorization process of the techniques presented that the analysis is brought to bear. Coding in qualitative content analysis can be both inductive and deductive, such that this paper drew on concepts identified in the literature review, including factors associated with prior disposition decisions. Factors such as insight, compliance, risk/threat, actuarial risk assessment or formal risk assessment, legal and clinical factors were identified, while a close reading of the texts allowed for further development of themes and ideas. Each case was read, identifying the main concepts related to the discursive process of conceptualizing the NCRMD individual's risk. This was done for all cases, and to the point where saturation was reached insofar as no new themes or ideas were presenting themselves in the cases under study.

The ten main categories identified included: the notion of insight; compliance – with medication or with treatment; notions of health-and-wellness based on behaviour or perception; family or community surveillance; professional or psychiatric surveillance; values; risk factors (formal professional risk assessments and actuarial risk assessments); temporal factors (including stability, decompensation, detention periods, patterns of behaviour or trend lines); evidentiary standards (rejecting or accepting particular evidence or exhibits). Ultimately these categories formed the basis of the investigation and analysis of the material.

The coding process occurred in a stepwise fashion, following the recommendations of Zhang and Wildemuth (2005) in conducting a qualitative content analysis. The first step was to prepare the data; in this case it simply meant acquiring the sample of cases that met the selection criteria identified. Step two was to define the unit of analysis. As mentioned, ultimately the unit of analysis consisted of particular themes present in the rationale for decision, either in particular words or phrases or throughout an entire paragraph or document. The notion of a theme was not confined to a particular textual unit length; rather themes were represented by expressions of an idea, not simply a term or phrase. For example, in a discussion about the insight of an individual found NCRMD, the focus was not simply on the term “insight” but the context surrounding its use, and the evidence presented as apparently, or not, relating to the individual’s insight. The selection of relevant factors in the text will be delineated more clearly in the following steps, but this example gives an idea of the abstraction capabilities of an open qualitative content analysis.

Step three involved developing a coding scheme and categories within which to place relevant codes. According to Zhang and Wildemuth (2005), categories and coding schemes can be derived from three sources, including: the data itself, prior research studies, and relevant theories. Thus, category and coding scheme development can be done either inductively (categories are derived from the text *in situ*) or deductively (categories are derived based on a preliminary model of categories), or both, whereby a preliminary list of categories or terms are used at the beginning of the coding process, but the categories and model are modified as new categories and ideas emerge inductively from the data. This study employed the latter model, whereby particular notions of the factors involved in a given disposition decision have been articulated – the notion of insight, the notion of medication compliance, and the notion of risk – however, these terms are not determined in the literature by anything specific, rather they are

taken at face value. The model deployed here was to identify how these terms and other categories of terms are conceptualized and used to configure discursive structures around the individual found NCRMD. A coding scheme was developed to help track existing codes and new codes, as well as allow for iterative comparison within codes in the event that the definition of a theme changed over time given the data.

Ultimately, the final step was to code the entire corpus of the NCRMD texts. Before coding the texts, each case was read to get a broad sense of the structure of the cases and how they are written. The rationales for decision are presented in slightly differing structures, but mostly follow the same steps – identifying the index offence, the parties involved, the life-course history and psychiatric history of the individual found NCRMD, the evidence presented at the hearing and finally the rationale for decision and the ultimate disposition. In the cases involving dissent, the dissenting opinions are generally presented immediately after the majority decisions. Of significance for this analysis was that a focus was placed on the portions of the case texts whereby the review board was presenting its own analysis of the evidence or its own justifications for a particular disposition. Previous research into case-level textual data for judicial decision-making incorporates the entire document without qualification, such that reference to the index offence, for example, will be inflated given the nature of the structure of the document. While it is important to understand the content of the entire document because it is, by definition, a summary of the case as understood by the members of the board and thus they can omit or include whatever is deemed relevant for a case, it is the justification process around those inclusions that is of greater interest here.

The group of absolute discharge cases was read apart from the group of detention cases, in order to possibly locate dispositionally relevant categories. Each case was read thoroughly,

initially looking for particular factors understood to coalesce in disposition decisions, like the notions of insight, compliance or overall risk, while accommodating other, new categories. Terms were highlighted with different colours, and placed into specific themes, initially based on the concepts identified. These subthemes were then analyzed to identify relations between the themes, in order to construct major themes. For example, the issues of insight and medication compliance were seen to be closely related as medication compliance often qualified insight and vice versa. The data was delimited and analyzed through subthemes and major themes based on the highlighted, coded texts, grounded in previous research and emanating from the texts themselves.

Methodological Notes and Limitations

The social constructionist stance engages an essential subjective interpretative understanding of the material under study. Thus, while the analysis is valuable in terms of a nuanced understanding of the justification process of the Ontario Mental Health Review Board, it is of course simply one subjective interpretation of the data. Future research could very well locate a differential interpretation and understanding of the same data or a different sample. Importantly, however, this is not necessarily a limitation as it aspires to consolidate a multitude of understandings that while not necessarily generalizeable across samples or populations, can provide new forms of consideration in the evaluation of policy, praxis and standards.

The limitations are a direct result of the very nature of interpretative work and qualitative study. Latent meaning is inferred, as one is simply interpreting the products of a performance, such that it is impossible to ‘know’ true intentions. The process does, however, still offer a window into one aspect of the research phenomenon, which can be supplemented by further lines of inquiry to arrive at a fuller picture through triangulation (Berg, 2009). A strength of this

methodology is that it can identify both overt and covert phenomena, since it investigates the text both for manifest descriptions as well as contextual semantics underlying the rationale for decision. Furthermore, it offers a point of departure for future research in analyzing the rationale for decision in other provincial review boards, and across different periods of time.

Huckin (2004) and Babbie (2008) both suggest that reliability can be seen as a limitation in qualitative content analysis, given its epistemological stance. There is no ‘reliable’ way necessarily to interpret meaning in discourse; rather, it is open and subject to revision, such that a deeper understanding will be sought. Sadler writes “if other members of an interested community find reason to reconsider selections and discussions, so much the better” (2005, p.18). The other limitation generally proposed regarding qualitative analysis relates to its validity, insofar as it is suggested that the interpretative process lacks generalizability and validity due to its interpretative nature. Onwuegbuzie and Leech (2005) and Huckin (2004) both reject this assertion, arguing that indeed all data are interpreted by researchers, and it is in this interpretative experience that a deeper, more nuanced analysis can be derived. Unique, richer descriptions of the data, sensitive to the contextual factors involved in the interpretation process, are a highlight of the methodology of qualitative analysis.

In terms of qualitative research, traditional concepts of validity and reliability are understood in the sense of trustworthiness (Guba & Lincoln, 1994). That is, it is important for the researcher to document their research process to the extent that it can be interpreted by others interested in the project, and even if they disagree with the interpretations, they can understand at least in part how interpretations were conducted and the decisions made. It is for this reason that this chapter has clearly delineated the data collection process, selection criteria, sampling, theoretical framework, and stages of content analysis to ensure credibility (Zhang & Wildemuth,

2005). Once more, in terms of credibility, threats may be identified from having a single coder throughout the data analysis process. In some forms of content analysis, inter-rater reliability is documented by having multiple researchers code the same material in hopes that they will reach a certain level of agreement. Armstrong, Gosling, Weinman, & Marteau (1997) argue, however, that in the case of qualitative content analysis, it cannot be expected that various researchers will identify the same themes or come to the same interpretations of those themes given that they are analyzed subjectively and contextually. Credibility and transparency are established, however, in documenting the steps listed above in order to organize the process as much as possible for others to understand the direction of the research and conduct their own subsequent analyses if warranted.

The research project was an archival study, and thus is more likely to have missing information than a prospective design that would plan for contingencies in the data and seek specific elements. Furthermore, it was limited to one province for the purposes of data saturation and resource constraints. Given the exploratory nature of the project, however, and the noted lack of generalizability, it was deemed prudent to focus on one particular province, such that future research could seek to interpret and identify particularities in the justification process of other provincial review boards to broaden the scope of analysis.

Additionally, the data reflect only a subset of the NCRMD population from 2004-2014, thus it is possible that the characteristics of the review boards and the population under study have changed or will change over time. Once again, the understanding of the systemic operations of the review board are seen to encompass changes in populations, thus this is less of an issue in this case where comparison is not necessarily sought between populations or time periods.

There may well be other factors involved in the decision-making and justification process that are not present in the written rationale, either by design or not. Interviews are possibly helpful in determining other factors involved at a heuristic level, as a source of triangulation. Also taking part in live hearings, transcribing them and comparing the discussion with rationales would be a way of triangulating the data collection and interpretation process. Transcripts of the cases may have provided more details about the cases, leading to a more nuanced understanding of the factors influencing judicial decision-making. Nonetheless, it was deemed important also to identify what was deemed worthy to include or omit from the written rationale as an official document of the review process. Additionally, in an ethnomethodological sense, not being a “member” of the review board as a system might constrain understanding from the perspective of an outsider regarding the vocabularies, systems of meaning and processes used by this system. It is argued, however, that being reflexive rather than insular in analyzing official justifications for social processes is imperative for more concrete understandings.

A final limitation has to do with the methodological decision to focus on dissenting opinions. It is possible that dissenting opinions on their own proffer different interpretations or more complexity than would ordinarily be dealt with and may alter the interpretations being made compared to cases that do not include dissent. While this is possible, it was a decision made in the interest of drawing out more complexity and ambiguity in the cases for a richer context of study. Regardless of the propensity for dissent, it is a useful endeavour in interpreting the underlying justification process of the Review Board in constructing the rationale for decision.

Ethical Considerations

Israel (2004) suggests that confidentiality of the material is negotiated through the interaction between the researcher and the participant. In more complex cases, however, confidentiality can be renegotiated as the needs of the researcher or the participant change. Thus, confidentiality is rather dynamic – both in terms of how it relates to that agreement between researcher and participant, and how it is negotiated in terms of access to that participant's information and pressures from outside sources. Confidentiality has ethical, political and legal dimensions that are weighed differently given the context of the research, such that it cannot always be assured in absolute terms. In terms of this project, the notion of confidentiality relates to the management of the legal cases and what is produced in relation to those cases and the actors involved. While efforts were made to remove qualifying information about the cases that might identify a given individual directly, it is impossible to completely limit this when for the interests of the study the material is in the public domain. It is indeed essential to present quoted text as is, and the cases themselves are available publicly. Where quotes are used to exemplify particular themes, the text is presented verbatim, except where names are used they have simply been reduced to initials. The cases have been cited by their initials with identifying case numbers in the Table of Cases.

In terms of this particular research project, much of the typical ethical considerations are beyond its scope insofar as the material is already part of the public domain as secondary or archival data. In saying this, there is a consideration of who exactly should be given confidentiality, especially as it pertains to those working in a public domain (Israel, 2004). It is argued in this case that the information is part of the public domain and is in fact meant to be in order to offer transparency within the judicial process, as it forms the basis for precedence in

future cases. Further, as the research pertains to a vulnerable population in terms of those who are criminalized and mentally disordered, there is an awareness of the potential ramifications of releasing a research project that could potentially influence policy and praxis in relation to this population. While it is impossible to conceive of every potential consequence, it is important to maintain the broad notion of ethical responsibility and reflexivity in the research process in general.

Results and Discussion

The following section outlines two main themes along with related subthemes that are found to define a specific risk profile and the attendant social ordering arising out of the justification for decision-making process of the Ontario Mental Health Review Board. The following analysis is based on an understanding of a networked neoliberal social system managing space, risk and individuals through varying systems of control or technologies of governance under a shared discursive ideology. The referents are identified in the cases under study, with several excerpts from the texts that help conceptualize the themes and ideas. The first theme, “A Medicalized Objectivity”, defines the medicalization of terms in the construction of legitimacy and objectivity in determining dispositions; the terms insight and compliance, and a spectrum of health-and-wellness are deployed in such a way so as to legitimize particular understandings of the individual found NCRMD and their potential threat to the safety of the public. The second main theme, “The Administration of Risk”, refers to the management and administration of risk across an archipelago of actors and locales, diminishing the purported expert role of the psychiatrist in a clinical sense, but legitimating the technologies of psychiatry as an expert system for the quotidian administration of risk. This second primary theme encompasses the institutional and custodial administration of risk, as well as control and surveillance efforts in the community. Other agents not explicitly connected to the mental health review board system are responsabilized with the surveillance and management of individuals who are discharged, demarcating a particular ethics of behaviour underlying normative standards of living through quotidian concerns into the lifestyle choices and placements of an individual found NCRMD.

Selected excerpts from dissenting opinions in the cases under study have been included throughout the results section to illustrate a particular systemic operation wherein incongruity is formally ignored. While dissenting opinions are presented in the cases, the majority opinions tend not to reference the topic(s) of dissent in their judgments at all, or when they do, it is limited simply to suggesting they disagree with the opinion of the minority member(s). It becomes an issue of clarity, wherein the justification for a particular decision is in fact not elaborated as one would expect given that there is explicit dissent. Differences in how certain evidence is interpreted as related to an individual's insight or the historical progression/regression of an illness is left out of the rationale for decision. Additionally, the dissenting opinions, either by design or circumstance, are generally written in the same generalist format as the majority decisions, thus obscuring the nature of the justification process in both majority and dissenting opinions. One of the two main issues of contention noted in the dissenting opinions is the idea of temporality, i.e. the temporal or time-dependent aspects of decompensation, medication compliance, and overall length of time spent under the purview of the Board. This issue is discussed in depth under the section covering Health and Wellness. The second main issue has to do with the issue of control over the management of the individual within and without an institution, including the issue of abdicating control over the individual found NCRMD to a forensic hospital. This issue is covered in depth in the section titled *A Confusion of Tongues* under the section on the Administration of Risk. Given that within a case the board members are drawing on the same evidence presented, it is intriguing to note the lack of description or justification for accepting a particular piece of evidence or not, and/or given the explicit dissent, a lack of explanation as to why or how a piece of evidence was interpreted or understood in a specific way.

Therefore, while methodologically it was hoped that identifying cases with explicit dissenting opinions might encourage more nuanced justifications of the reasoning for particular dispositions made, the results section is not necessarily a comparison of majority and dissenting opinion in cases, rather they are used as indicators of a particular way in which the Review Board positions itself around the individual found NCRMD and its potential justificatory process as an organization, rather than as disparate cases existing in a vacuum.

Ultimately, the results section will lead to a more nuanced discussion of the development of social praxis that is aligned with a particular ideology and its presence across social institutions in the maintenance and progenation of systems of control through the governance of risk. That is not to say they are necessarily insidious, exerting power wantonly in order to actively subjugate individuals. It does, however, reconceptualize the presupposed legitimacy and objectivity associated with a medicalized knowledge system by reorienting our notions of independent social institutions and complexes (the carceral complex, educational institutions, medical system, psychiatric or mental health complex) with a more muddled picture of rhizomatic knowledge dissemination and by extension behavioural control across and within networked systems of control; ultimately defining a particular *finalité*² of the review board system.

A Medicalized Objectivity

In the cases under study, a certain pattern emerged in the rationale for decision. For the majority of the cases, save two of them where it appeared a decision may have more or less

² The notion of *finalité* is understood to mean the teleological orientation of a system, that is, the general principle of the direction of a system. The notion of *finalité* cannot be reduced to a goal or a function: it refers to the character of something striving towards an end and implies processes through which the end is attained (e.g. adaptation of the means to the ends or adaptation of the parts to the whole). *Finalité* applies to a system or institution, not to its individual actors within, hence it is not necessarily consistent with the expressed intent of those actors nor with the manifest political or social ‘objectives’ of the system (Dallaire et al., 2000, p. 693).

already been made prior to convening, the judiciary described the accused's capacities and ability to avoid being "at risk" based on their level of insight, their level of compliance with medication specifically, rather than the broader notion of treatment, and their health and wellness. Ultimately, the description of each case followed a pattern whereby these factors are checked off as either satisfied or not, which consequently adjudicated the individual's potential threat to the safety of the public.

Insight

The notion of insight is used consistently and presented as a concrete phenomenon, yet in no decision is there mention of a relevant test for insight, practical way of interpreting insight, or a consistent conceptualization of the term. Rather, it appears there is a shared understanding of the term across parties, despite the differing technical backgrounds involved in the review boards. Hamilton and Roper (2006) argue that in mental health assessment the concept of insight is constructed through two points of view – that of the individual with a mental disorder, and the amalgamated opinion of the various professionals involved in the case, assuming that the professionals all understand insight in the same fashion. The authors argue that the complex topography of insight "defies distillation into any simple or useful pronouncement of a level of insight" (Hamilton & Roper, 2006, p. 417). Insight is seen to consolidate a multitude of opinions and ways of evaluating and understanding the global conceptualization of the capacities, values and behaviours of the individual into a neat presentation of a legitimated medical concept.

For example, in *Re SA*³, the Board states that the accused has "good insight into his illness and understands that he will be required to take medication into the foreseeable future",

³ Quotes from the cases are reproduced verbatim, including any typos or errors in the text. The names of the parties involved have been replaced by their initials. Cases are cited as *Re [Initials]* and referenced as such in the Table of Cases.

then within the same paragraph states that the accused has “a fair degree of insight regarding his illness”. There is a clear lack of clarity in distinguishing between levels of insight, such that it appears to fall along a spectrum without clear delineation. Similarly, in *Re KO*, the accused is described in three short paragraphs as having “remarkable insight”, that the accused’s insight “was hampered by their deteriorating mental status” and that the accused was previously “very insightful” but now showed only “flashes of insight.” In these cases, it is a very tenuous link being made between the global term insight and the particular elements purportedly related to insight, as well as how to apply the notion of insight to a given case.

Ultimately, across the decisions, a spectrum of insight emerges, with one end being an apparently acceptable degree of insight:

Has good insight into his illness; the hospital report comments favourably on his insight this year; demonstrated good insight; demonstrated sound insight; his insight is adequate.

While the other end suggests an apparent lack of insight:

He exhibited poor insight; his insight is not full; inconsistency in his insight in the past; less than stellar insight; little insight if any; showed a continuing lack of insight; he has very little insight; the accused appears to have no insight; he lacks insight.

While the cases suggest the accused can entirely lack insight (“he lacks insight”; “the accused appears to have no insight”) there is no mention of someone having “total” insight, suggesting the continued opportunity to improve insight and thus their attendant productivity in light of that. As an element of evaluating the potential risk of harm, the notion of insight situates the individual at a negative level of risk. One can lack insight entirely, but one cannot ever attain total insight, such that it can be used to negate potentially positive behaviours. In *Re RDB* the

Board explains the notion of insight as an essential factor in arriving at an assessment of risk, stating:

RDB's insight may have wavered, but the question for the Board, on all the evidence, is whether he has sufficient insight into his illness and the need for medication. A majority of the Board concludes, on balance, that he does not lack the insight that would make him a significant threat to public safety

Importantly, as discussed in the section outlining the structure of the review boards, the notion of *mental condition* is the concept under scrutiny for the review board in evaluating the mental faculties of the accused. The term "mental condition", however, is not defined through legislation or case law for the review boards; rather it is conceptualized *in situ*. It is in this way that the concept of insight is used to operationalize the concept of mental condition of the accused. This discursive turn allows the review boards to hold apparently paradoxical understandings of the mental capacities of the accused, insofar as the review boards tend to identify the severity of the offence as a critical factor in determining disposition decisions. There is an incongruity, however, in suggesting that an individual who was deemed incapable of appreciating that the nature of their index offence was legally and morally wrong is more or less likely to recidivate based on the offence they previously committed. If this were the case, then it suggests that the individual deemed NCRMD was somehow capable of understanding that lesser offences were wrong and thus should not be committed, while the more severe offence was acceptable, and that this cogency of interpretation would be temporally reproduced in the mind of the accused.

Despite the widespread use of the term insight, the ambiguity observed in its use is highlighted by dissenting opinions arguing for different interpretations of insight and what this should entail with regard to managing the individual found NCRMD.

In Re BLA, the majority do not refer to insight in making their disposition decision, rather they refer to the accused's improved "mental status" and potential for medication compliance, stating:

We are satisfied that given the evidence identified by Mr. H., notably the fact that following the initiation of Clozapine just over a year ago BLA experienced a dramatic improvement in his mental status and his behaviour, there was evidence to support the view that BLA will again respond positively to the reinstatement of Clozapine, that he will stabilize on the medium secure unit, and that the potential exists for him to be safely returned to and managed on a minimum secure unit over the course of the coming year. Thus the majority members determine that a hybrid detention order wherein the forensic hospital managing the accused is given the ability to move the accused between medium and minimum secure psychiatric units is satisfactory given the accused's mental status and medication compliance. In the dissenting opinion, however, the Board member disagrees with the hybrid order and requests a detention order on a medium secure psychiatric unit only, without the ability to move down in level. The basis for this dissent is argued on the lack of insight demonstrated by the accused into their illness or the need for medication compliance:

The hospital report makes it clear that BLA does not have adequate insight into, or understanding of, his mental illness and his need for medication. He has a history of non-compliance with medication & follow-up in association with eight earlier hospitalizations extending from 1995 until, and including, the period of two to four weeks prior to the

index offence. When he does not take his medications his decompensation occurs quickly.

The issue in comparing the two opinions in this case is that the majority opinion is not clear in how it has determined “mental status”, but it would seem to compare closely with the notion of insight, in as much as they both refer to an abstract ability to understand the source of one’s behaviour and the existence of a competing mental disorder. It is difficult to follow the logic of the Board’s justification, because if the terms are interchangeable there is a clear disjuncture in how this notion has been interpreted which is problematic given the high stakes of review board determinations in terms of an individual’s liberty. If the terms are not interchangeable, then it is similarly unclear how these two contrasting interpretations of an individual’s trajectory, given the same evidence, have been determined.

Another case demonstrating a lack of clarity in the application of the notion of insight is found in *Re MS* wherein the majority members write that “the Board agrees with Dr. H's assessment that MS at this time continues to present as a significant threat to the safety of the public. In the context of a most serious index offence, that risk lies in the absence of full insight by the accused into his major mental illness and his non-compliance with medication in the past”.

It is important to note here that in this particular case, the majority have determined that lacking “full insight” is indicative of significant risk to the safety of the public, despite the fact that in no other case had any of the accused been described as having had full insight, including those given an absolute discharge. Furthermore, it is left unclear how the accused might attain “total insight” into understanding the very nature of their mental illness. It is a potentially harmful consideration to require an individual to apparently understand their behaviour and

conceptualize a tendered illness, especially in light of a “most serious index offence” given that the seriousness of the offence would not necessarily impinge on a required level of insight. If it does, then it is suggestive of the Board that there is an insight-threshold to be met in light of the appraised seriousness of an offence, similar to how burden of proof is related to an offence in the legal system. The difference here is that there is nothing to suggest this threshold exists beyond *in situ* concerns, and nothing to delineate the severity of offence in NCRMD cases.

The majority opinion continues to draw on the evidence presented by the attending psychiatrist, stating that “he has had a difficult time adjusting to life outside the hospital in the past and is described as being “fragile” and in need of close monitoring”. This is an important issue because in the evidence presented by the attending psychiatrist, the psychiatrist states that the accused’s “illness is fragile”. It is a slight nuance but important in conceptualizing an understanding of the individual in light of a dissenting opinion that in fact argues that the individual has adequate insight and the ability to manage their illness in the community without the purview of the Board.

It would seem essential for the Board, in documenting its justification process, to identify possible areas of misrepresentation in order to ensure clarity in its process. Indeed, the minority dissenting opinion argues “the accused’s insight has improved over the years...according to the Hospital Report MS showed improving insight into the fact of his illness and need for treatment. According to Dr. H, MS acknowledges that he has a major mental disorder and understands that he required medication on an ongoing basis”.

Thus, the minority opinion is similarly drawing on the evidence proffered by the attending psychiatrist, yet with a distinctly different interpretation of the emphasis and import of the elements of the testimony. It remains unclear how this issue was resolved, insofar as there are

two competing interpretations of the accused's insight and the potential fragility of their illness and behaviour in general. In this case, the notion of fragility apparently implicates insight, as it is the fragility of the accused's illness and understanding thereof that would indicate a lack of adequate insight.

The complexity of the role of insight in the justification for disposition decisions is heightened in light of dissenting opinions that either interpret the same evidence as indicating different levels of insight, or in how insight is to be understood in light of other factors determinative of a particular level of risk.

For example, In Re CC an absolute discharge was given by the majority of the Board. The minority of the Board argue that the accused should receive a conditional discharge based on an "an analysis of risk set out in the Hospital Report" at a previous hearing a year earlier. The dissenting opinion states "Dr. C and the treatment team specifically stated that he 'remains poorly insightful into his illness, the need for medications, and the potential risk associated with substance abuse'".

This is interesting given that the minority are referring to a document presented to the Board a year ago, while the majority members state that based on the evidence submitted by the same attending psychiatrist, the accused "has only superficial insight into suffering from a mental illness and the importance of medication. Nevertheless, Dr. C believes the accused will likely remain on medication in the future. He believes it is helpful to him".

The majority apparently accept that the accused had advanced from being poorly insightful to superficially insightful, and state that "CC himself is credible in stating that he appreciates the effects of the medication, he doesn't wish to change his current residence and has considerable respect for and support from the owner of the house. He is well settled and has no

immediate plans to change his living environment, which is the structure that is assisted in maintaining his stability.”

The majority also argue that the accused’s apparently limited insight is mitigated by a stable living environment and an appreciation for the need to take medications. In this case, however, the minority are not persuaded by the most current evidence, rather they refer to prior evidence suggesting that the accused has “poor insight”. Thus the notion of insight is seen to be the ultimate issue in this case; however its importance or how it is correlated with both historical and external factors is understood differently by members of the board. The fact that insight itself in this case is never operationalized concretely by the members of the Board as differentially appraised (poorly vs superficial) leads to some ambiguity as to how it is implicated in the justifications for the members making a particular disposition.

In another case, Re JX, the majority members of the Board agreed on a disposition of an absolute discharge, stating:

We find that the accused's mental illness, primarily, the major mental illness of schizophrenia, has been largely under control for more than three years...He clearly requires close and careful monitoring and support, and that will continue through the PROACT Team, which is now prepared to assume responsibility for JX's care...The accused has gradually moved into an internally motivated acquiescence, even without full insight, and has developed a therapeutic rapport with the treatment team.

On the other hand, the dissenting opinion recommending a conditional discharge order argues that the accused has “little insight into either his illness or the importance of his medication to his continuing wellness...this raises the concern as to whether he would see the need to continue taking his medication if given an Absolute Discharge”. The conceptualization of insight and its

deployment here differs from the majority opinion in that it is suggested that insight remains the clear determining factor for an individual's level of risk, while the majority decision suggests that insight itself as a factor can be mitigated by the presence of external mediators. This issue is understood in more depth in the section on the Administration of Risk. However the majority of absolute discharge decisions are aligned with an existing agreement for external psychiatric treatment teams to oversee the absolutely discharged accused for observance outside the purview of the Board. Within a single case, the notion of insight is not unanimously understood in terms of a measure of risk, or as a mediator between factors related to an understanding of risk.

Furthermore, the notion of insight in *Re JX* is mediated by inchoate reference to the accused's potential for self-regulation – “this raises the concern as to whether he would see the need to continue taking his medication if given an absolute discharge”, and “the accused has gradually moved into an internally motivated acquiescence, even without full insight, and has developed a therapeutic rapport with the treatment team”. The majority opinion is that accused indeed lacks full insight, but through an “internally motivated acquiescence” and a relationship with an external psychiatric resource, could be deemed appropriately managed in the community. Importantly, the term “internally motivated acquiescence” suggests what could be termed a level of subjectification on the part of the accused as they come to model their behaviour and understanding of the self in light of this particular psychiatric project (Rose, 1991b).

As Rose (1991b) suggests, psychosocial rehabilitation serves to conceptualize and alter the individual sense of self in order to effect change at the level of personal conduct. The “self” is a term used to acknowledge the subjectivities of individuals, through the technologies of the psy-disciplines to consider their own actualization and act upon it. This is conceptually related to the notions of identity and governmentality, insofar as the rationalities of government have

developed to consider political bodies at both an individual level, where the individual can consider their nature as productive and actualized persons, and at a group level that defines and constrains those fields of consideration. The development of the psychiatric domain of interest over behaviour becomes problematic, however, because the system of knowledge acquisition it is based on and its underlying epistemology is intrinsically tied to and confounded by political institutions, most readily a politics of risk. The way the concept of intervention or treatment is defined is critically related to the concepts of psy-disciplines and governmentality defined and constituted by those in power. Systems of knowledge, including psychiatry and the knowledge of the self that it purports to know and understand, become systems of production rather than investigation, such that our concept of what it means to be a productive or actuated individual are defined by these pre-established knowledge systems (Rose, 1991b; Cruikshank, 1993).

Insofar as psychiatry is an effort in production, Rose (1991b) suggests that psy-disciplines established themselves as a self-referential system through regimes of truth and the psychologization of a range of phenomena. Regimes of truth are seen to delineate what can be considered “real” and “valid” about an individual, object or circumstance, and are simultaneously constituted by the very apparatuses used to define truth. Psychiatry becomes necessary in dealing with the issues defined by authorities as pertaining to the psychological domain and evaluating the claims of psychological truths, in concert with the dominant notions of morality, ethics, and authority in a neo-liberal environment. Thus, the way that psy-disciplines develop knowledge of the self is constituted by an array of socio-political factors and institutions. The notion of a successful intervention becomes less about what would be normally considered of psychological relevance, and more about the state’s capacity to influence conduct through the notion of self-governance. Intervention seeks to associate and align individual

subjects with a certain status quo. Changes in conduct and the self are necessary insofar as intervention is a technique of subjectification. Under the guise of psychiatric discipline, intervention necessarily requires change in conduct through a change in identity such that people come to be constituted by the ethics and values of the dominant political ideology in society – what comes to define the status quo. Regression from the supposed empirical norm within any institution therefore reflects deviance, and thus requires intervention to effect change in that individual's conduct through reformation or reconstitution of the self in order to maintain social control (Rose, 1991b). In the case of Re JX, and others, the reformation of the self occurs in light of an acquiescence to an ascribed identity defined by a major mental disorder and the attendant need for psychotropic medications in order to waylay the risks posed by the supposed nature of the individual.

Intervention and the notion of the self become the foundations of a way to promote self-regulation. The locus of control shifts from those in power to the individual, who voluntarily seeks out this self-referential system of experts and knowledges in order to align their sense of self with the moral and ethical subject (Cruikshank, 1993).

Ultimately, the rationalization of a particular mental condition and insight lays the groundwork for an incongruity in the rationale adopted by the review board in ascribing particular labels and levels of risk to individuals in order to structure their existence within and without the community.

Conflating Insight and Medication Compliance

Ultimately, insight is generally used as a qualifier for other terms that are related to the accused's risk profile. These other terms are used similarly in that they hold no specific definition and have no apparent test or explicit way in which they are deployed, but are used all

the same consistently within the rationale for decision to describe and define the accused's level of risk. The most significant of these terms is the notion of insight into the accused's illness and their subsequent need for medication. Thus, the Board identifies the notion of insight as directly related to whether or not the accused admits to having the particular diagnosed disorder ascribed to them, as well as their attendant need for medication for the treatment of that disorder.

Adequate insight is seen to hinge on the accused aligning their construction of the self with a particular diagnosed psychiatric disorder and the need to treat that disorder with psychotropic medication.

In mobilizing insight, the Board often conflates the term with a general reference to medication compliance. Of interest here is the idea that compliance is strictly related to psychotropic medication compliance, and not simply compliance with treatment in a broad sense. While the legislation surrounding the issue of detention and treatment is necessarily vague as it relates to specific forms of treatment and intervention, subsequent policy and case law refer directly to medication as the uniform definition of treatment (OHA, 2012; Verdun-Jones, 2014). This suggests a particular focus on a medicalized form of intervention, where psychotropic medication is *de rigueur*. As mentioned previously, but of particular significance in this respect, is the continued advancement of biomedical concepts and evidentiary practice into the DSM and the way in which disorders are understood, defined, and treated (Kawa & Giordano, 2012). In addition to a greater than 300% increase in the number of disorders defined in the DSM over a 60 year period, of the authors involved in selecting and defining psychiatric categories for inclusion in the DSM-IV, 100% of those who sat on panels for severe mental disorders such as schizophrenia and bipolar disorder had financial ties to the pharmaceutical industry, suggesting a potential conflict of interest in light of treatment ideals (Cosgrove et al., 2006). Significantly,

approximately 80% of individuals involved in the national mental health review board system are diagnosed as having either a psychotic or severe mood disorder, including schizophrenia and bipolar disorder (Crocker et al., 2015b).

In conflating insight with medication compliance, the Board is suggesting that a reasoned individual would necessarily agree to a particular form of intervention, namely medication compliance, discounting the possibility that the choice to refuse treatment could be a result of a cost benefit analysis by the accused (Diesfeld & McKenna, 2005; Hamilton & Roper, 2006). Ultimately, the notion of insight and its conflation with understanding the determined idea that they are disordered and in need of psychotropic medication is the primary risk factor under consideration for the Board. For example, in *Re RDB*, the Board states that, in making its ultimate decision regarding whether or not the accused poses a risk of significant harm to the safety of the public, “the answer turns, primarily, on whether the Board is confident that he has sufficient insight to continue taking his medication after discharge”. Similarly, in *Re MS* in the context of a detention order, the Board states:

The majority of the Board agrees with Dr. H’s assessment that MS at this time continues to present as a significant threat to the safety of the public. In the context of a most serious index offence, that risk lies in the absence of full insight by the accused into his major mental illness and his non-compliance with medication in the past.

Once more, in *Re SG* as part of the summary of risk factors taken into account in making an absolute discharge decision, the Board states:

The accused has a continuing need for anti-psychotic medications. He has almost no awareness of externally obvious psychotic symptoms, which are mild but which continue. His understanding of his illness is described as superficial...but [with the help of the

Assertive Community Treatment team] there is no real chance of non-compliance and without non-compliance there is no significant risk.”

In this particular case, the accused’s presumed lack of insight into their illness is moderated by their continued medication compliance. What this suggests is that insight is related to risk through compliance. Insight is ultimately understood as a mediator of the link between medication compliance and risk. That said, in this case insight on its own is less of a concern due to the presence of an external control mechanism in the form of the Assertive Community Treatment team. Therefore, insight is most relevant as an indication of an individual’s capacity for self-regulation and self-surveillance in light of being medication compliant.

In Re JX the Board obfuscates a particular relationship between so-called antisocial behaviour, the proposed illness, and treatment compliance, writing about the accused that “his antisocial conduct and noncompliant treatment suggest that his mental illness and his criminal conduct are intimately linked. Once his mental illness stabilized and he was provided support, then the antisocial behaviour has not continued.”

Insight and medication compliance are also conflated with regard to the development and continued demonstration of insight and its direct relation to their perceived risk of significant harm to the safety of the public. In Re RDB the Board states:

Overall, there is considerable evidence that RDB has insight into his illness and its connection to the index offence and the need for medication. He has established long-term compliance over a period of years, has acknowledged his illness and the benefits of medication...the question for the Board, on all the evidence, is whether he has sufficient insight into his illness and the need for medication. A majority of the Board concludes,

on balance, that he does not lack the insight that would make him a significant threat to public safety.

Further, in Re JH the Board states the accused “has good insight into his mental illness. JH recognizes his illness and recognises his need to take medications.” Then, in Re CJ the Board writes that the accused “intends to remain compliant with medication. His insight into the need for medications is adequate and he intends to remain compliant.”

The conflation of insight and compliance as a dynamic process, rather than an inherent, static one, suggests the implicit requirement of particular psychiatric programming in order to ensure the development and maintenance of such insight. For example, in Re JB the Board states:

Previously, JB has had less than stellar insight, but now he does understand the need for and why he is taking medications. As a result of the programs he has attended his insight has improved. JB has indicated that he understands his illness is related to his index offence and that once discharged he knows he must continue with his medication.

In this example, it is clear that the Board is establishing a relationship between the programs that the accused has taken while in hospital and the attendant increase of insight into his need for medication. Thus insight can be improved, primarily, through psychiatric intervention.

Similarly, where an accused in fact openly disagrees with the role of medication and programming, they are considered to have diminished insight. Once more, the incongruity with the notion of insight and the disagreement between accused and psychiatrist is present, insofar as insight can only necessarily be shown in congruence with the opinion of the expert coordinating the management and treatment of the accused. In Re VD, the Board writes

He showed that he had little if any insight into his diagnosis, illness, and need for treatment...VD was missing three doses of his medication per week...He showed a continuing lack of insight regarding the effects of substances on his mental illness and behaviour including the need for treatment. VD also advised Dr. W that he had stopped taking his medication in November and December, 2011.

Furthermore in Re KO, the Board writes “the Board, in the course of the evidence from Dr. C, was advised that the insight had been hampered somewhat by KO’s deteriorating mental status. KO is described as being mistrustful in dealings with staff, especially with respect to medications and food.” Thus, the avoidance of medication, even when it is openly discussed, is seen as an individual lacking the necessary insight to realize their “need” for a particular treatment. In another example, Re WM the Board states “he lacks insight into the fact of his illness or the need for treatment with psychotropic medication. In fact, he feels he does not need medication.”

One interesting case, Re SP, presented a situation in which the relationship between the accused and the psychiatrist was noted as “remarkable” (abnormal), and described in the following terms:

The doctor described the accused's request to reduce his medication as a positive experience and that the accused approached the issue politely, respectfully and reasonably. As a result of that trial, the accused is maintained on a lower dose of Clozapine than he has been previously. The ‘instability’ which resulted during the course of the adjustments in the dose of Clozapine, did not result in SP's readmission to hospital or any violent, aggressive or threatening behaviour. This is not the type of case where an accused repeatedly asks for a reduction of his medication due to a lack of insight into the

need for some. The accused has insight into his mental illness, his need for medications and he believes that Clozapine is the best medication for him.

This case presents as unique insofar as a request for the reduction in medication is in fact seen in a positive light. In analyzing the exchange, however, it suggests that the attending psychiatrist was never at odds with the request, and the accused's request is not in conflict with the dominant ideology that a specific form of treatment and medication is required to treat their conduct. It is simply a matter of fine tuning for this treatment regimen. In line with this understanding, in Re AL the Board states:

AL indicated that he might wish to switch his anti-psychotic medication from his current medication of Clozapine to Risperdal which he had taken previously. Dr. D testified that he viewed this request as concerning given that AL had been doing extremely well on Clozapine... There was no evidence before the board that AL was insistent on changing his medications, merely that he had raised a question about this. This fact alone is not sufficient to negate the significant evidence that was before the board as to his continued compliance with Clozapine over the year.

While the Board rejects the proposal from the attending psychiatrist that the request to change medication was a direct concern, the Board suggests that an accused insisting on changing medications would be of some significance to the decision of whether or not the accused is considered a significant risk. Thus, these two examples outline the particular way in which an accused could acceptably be seen to counter psychiatric opinion, but only insofar as it is done "politely, respectfully, and reasonably", with only a simple question, and without significant insistence on the change. It connotes a particular subjugation of the accused in relation to the

psychiatric members who are taken to understand the needs and requirements of the individual without compunction.

Lupton (1995) notes that psychiatric authority and power is undermined when individuals under their control reject the labels and explanations that define the dominant discourses of psychiatry. This power exchange can be reversed through interpreting the non-compliance and refusal of treatment as lacking insight, in need of further intervention. Thus, insight and compliance are discursively aligned to the extent that they establish the accused as a subject of psychiatry who must be ascribed a particular diagnostic label and summarily agree with the proposed treatment. Insight is a conceptual paradox in that in order for an individual found NCRMD to establish they have insight, they must agree that they suffer from a mental illness (chronically or in remission), and subsequently must admit that when they are actively showing signs of this illness that they do not have the necessary insight to make rational decisions regarding their illness or behaviour. In the end, the acknowledgement of having been “ill” is seen in the first place to limit the potential insight an individual could attain. Where an accused suggests they are not ill or do not want to take medications they are considered lacking in insight, despite the fact they are potentially insightful enough to rationalize a rejection of treatment or to evaluate their own mental state. It is a discursive turn that places psychiatry as the top-down and sole expert through which insight can be adduced. Clearly the ability to determine insight on its own, whether it is present in an individual who is diagnosed as mentally ill or not, is difficult if not impossible to assess in an objective sense. Rather, indicators of insight might be adjudged differently if the term insight was eschewed in favour of the capacity to care for oneself, for example. Is the individual capable essentially of providing the bare necessities of an existence and if so, should they be considered capable to live in the community, unfettered. In terms of

determining insight as a rationalization for rejecting treatment, it could simply amount to a historical consistency in decisions regarding treatment options and an open dialogue between the individual and those treating them. It would stand to reason that if a clinician were conferred expert status to determine “global insight”, they could similarly determine the rationale of an individual either accepting or rejecting treatment – not in the sense of whether they necessarily agree with the decision, but simply whether or not the decision is somehow supported by a cogency of arguments. The issue with conflating insight and other terms is not so much that they are “right” or “wrong”, but that they are deployed as colonizing terms that delimit the potential space for alternative perspectives and understandings of behaviour, rationality and self-control.

Patient acquiescence to particular psychiatric terms and labels must accord with biopsychiatric practice otherwise patient explanations and evaluations cannot hold currency against a psychiatric system of experts and legitimated knowledge. Thus, treatment is seen to be necessarily coercive where rejection of said treatment is predetermined as resulting from the illness supposedly requiring treatment. In *Re SA* the Board writes:

The most significant risk factor for SA to become unwell has been identified as his history of inconsistent compliance with treatment...His risk to the public has been substantially reduced over the past two years, most notably by his clinical stability and his consistent with effective treatment.

In another case, *Re LV*, the Board questions the attending psychiatrist on the rationale for treatment compliance by the accused without consideration for the personal account from the accused:

Dr. P testified that LV was aware of the fact that he was not obliged to take medication, by virtue of the Board Disposition. Dr. P was asked why then did LV continue with

medication, and Dr. P replied, 'because LV wants to ensure that he does not become ill again in the future.'

In one case, the Board is seen to upbraid an accused for their tardiness and lack of acceptance of the administration of the hospital and review board. Anything less than total compliance is viewed as a possible threat to solvency of the psychiatric establishment and discourse. In Re BLB the Board writes that the accused:

Did not arrive until 10:30am. She offered no apology for being late nor did she offer any reason for being late... The Panel are unanimous in finding that the Accused continues to pose a real, present and substantial risk to the public... [due to a] lack of insight and a history of non-compliance... as a result, her borderline personality disorder often triumphs, her caregivers are manipulated because those at point "A" do not know what is happening at point "B" and vice versa. All the while, BL does things "my way", notwithstanding what is stipulated in the ORB Disposition Order... Moreover, consequences should follow if the accused fails to comply with the ORB's orders. If BL wishes to make a political statement because she is subject to the jurisdiction of the ORB and CAMH, she should find some other venue for her "*protests*".

This particular case evidences a somewhat unique instance of the Board seemingly dissenting from its usual disembodied and objective stance, clearly commenting on the impoliteness of the accused in being late, and while indicating the accused suffers from a personality disorder, the Board simultaneously holds them accountable for their apparently manipulative behaviour. This is an intriguing analysis as the Board cites a lack of insight on the part of the accused yet suggests they are capable of manipulative behaviour either due to or in spite of their personality disorder.

Ultimately, the conflation of the terms lends a particular medicalization to the issue of insight, in that in order to be considered a rational individual one must enter into a constitutive relationship with biomedical psychiatry, in the context of which psychotropic medication is used to deal with mental disorders on a grand scale (Kawa & Giordano, 2012).

Health and Wellness

As mentioned, a related conflation of terms occurs with the notions of insight and the mental illness of the accused. Ultimately, in forming a disposition decision, the Board weighs the accused's compliance and acknowledgement of the ascribed psychiatric diagnosis as essential components of their risk profile, asking whether the accused accepts that they are mentally ill. The issue with conflating these terms is that the diagnosis then becomes deterministic, and so too does the resulting treatment plan.

Additionally, and of particular salience here, is the fact that the DSM itself has a forensic disclaimer suggesting that the manual and its diagnostic categories should not be used in forensic determinations:

“When the DSM-IV categories, criteria, and textual descriptions are employed for forensic purposes, there are significant risks that diagnostic information will be misused or misunderstood. These dangers arise because of the imperfect fit between the questions of ultimate concern to the law and the information contained in a clinical diagnosis
(*DSM-IV-TR*; American Psychiatric Association, 2000, pp. xxxii-xxxiii)

This is important as the psychiatric system, in light of its connections with the criminal justice system, can be seen to be protecting its discourse and system of heuristics by suggesting that failures of interpretation or application of the manual and its attendant diagnostics would have to be attributed to faulty applications of categories within (or by) the criminal justice system. The

notion of secondary risk management will be presented in more detail below, but it is an important distinction and point of departure in the analysis of the interface between the two organizations.

In describing the accused, the Board tends to locate them on a spectrum of health and wellness, similar to that identified for the use of insight. Once more, the lack of explicit definitional criteria for such terms, concomitant with their general acceptance and usage, creates a legitimated vacuum of incontestability wherein negative ratings across this wellness spectrum are directly related to the conceptualization of risk of the accused.

On the positive end of the spectrum of wellness, the following terms or descriptions are used:

When stable; clinical stability; has been relatively stable; remains very stable; the major mental illness of schizophrenia has been largely under control; once his mental illness stabilized.

While on the negative end of the spectrum of wellness is the description of more highly observable manifestations or symptomatic elements of disorder, wherein the following terms or descriptions are used:

Unwell; the severity of his illness when he is not well; quickly decompensates; highly psychotic; deteriorating mental status; instability; fragility; very ill; acutely psychotic; described as being fragile.

Importantly, given the underlying philosophy of a disease model of mental health, individuals considered disordered are relegated to a lesser position – one where the individual is constituted by this disorder insofar as their conduct, rationalities and plans will necessarily be read against the background of their diagnosis and other clinical opinions (Hamilton & Roper, 2006; Lupton,

1993). Indeed, Sadler (2005) notes the morally-laden evaluative nature of the conception of illness and disease, suggesting that “wellness and sickness are natural siblings in the family of moral life” (p.5). It is the intrinsic undesirability of disease and illness buttressed by psychiatric and medical discourse around sickness that render health systems as morally laden. The general demand for scientific objectivity and so-called truth obfuscates the constructed and evaluative nature of illness. Ultimately, in describing the negative end of the wellness scale through clearly observable manifestations of various behaviours seen to fall on the spectrum comprising psychotic or major mood disorders, it opens the door to identifying nearly any behaviour seen to be detrimental to the individual’s treatment plan as indicative of decompensation.

Furthermore, Gorenstein (1992), a practicing psychologist, suggests there is an inherent problem with validity with respect to the diagnosis of mental disorders, summarized in the following excerpt describing how mental disorders are bootstrapped:

When faced with the defining symptoms [of schizophrenia] in a given individual, the average clinician would probably use the term schizophrenia to denote the syndrome in question. In a profound sense, the clinician would also be using schizophrenia to explain the syndrome, for the term is not intended merely to provide a convenient summary for features that can be listed simply on a sheet of paper. Rather, schizophrenia is intended to represent a property of mental functioning – an independent process – of which the many observable features are the result. The question naturally arises, however: how can invoking a term, whatever it represents, explain behavioural phenomena? Doesn’t this just create the illusion of an explanation? After all, if an individual behaves in a certain way, what is the value in saying that he does so because he is schizophrenic when the only way we have of knowing he is schizophrenic is by the way he behaves? The

reasoning appears entirely circular. There is, however, a way out of this circle. It involves demonstrating that the term schizophrenia actually has meaning beyond the set of behavioural events that are used to determine its presence. In other words, if we can show that invoking the term schizophrenia in a given case provides the means of making new and accurate predictions about an individual's behaviour, then we establish that schizophrenia is indeed an explanatory concept and not just a label for previous observations. (p. 60)

Ultimately, one creates a construct of the term schizophrenia, requiring independent explanatory evidence as to its natural existence beyond simply the behaviours used to define it in the first place. The idea of schizophrenia is based, arguably, on the behaviours it is meant to describe, rather than any inalienable explanatory value, becoming nominal rather than indicative of a phenomenon of which the behaviours are purportedly reflecting. As noted by Gorenstein (1992), simply grouping a set of behaviours and naming them schizophrenia does not relate any additional explanatory value to the term, rather it simply suggests that these particular behaviours represent a mental disorder because that mental disorder is defined by these particular behaviours.

On the Nature of Diagnosis

Only one sample case has the Board asking for a clarification regarding a term associated with the accused's illness. In Re RDA the Board asks for clarification of what the attending psychiatrist was referring to, stating "finally, Dr. de Jesus clarified what "quickly decompensates" means, and said that in RDA's case he would expect deterioration to take place over a period of weeks or months rather than days". Otherwise, these terms are used alongside insight to establish a level of risk for the accused in relation to the level of perceived control they

have over their ascribed disorder. Of significance here is that in the rationale for decision there is no indication of what is meant by “decompensates” or the apparently related “deterioration”. For example, in Re DD the Board writes “Dr. N tells us that he needs the ability to move the accused quickly without awaiting such a deterioration in the condition of the accused that would warrant a restriction of liberty.” The context in which this statement is made by the Board is in identifying the need to restrict the liberty of the accused through the condition of a hybrid order wherein the accused can be moved from low to medium security wings without further reviews, rather than a strictly low security condition. The potential for deterioration, then, is seen to reflect the possibility of risk on the part of the accused.

Additionally, the Board notes the accused’s diagnosed mental disorder in each case, but rarely expands on it. Rather it exists nominally as something used to define the individual. For example, in Re JB the Board states:

Having heard and considered all of the evidence and submissions from all the parties, the Board is unanimously of the view that JB remains a significant threat to the safety of the public...JB suffers from schizophrenia, antisocial personality disorder, polysubstance abuse in remission in a controlled environment. The Board recognizes JB’s progress during the past year; however, it is clear on the evidence before us that JB requires the ongoing structure and support of a treatment team to monitor his symptoms, conduct urinalysis and drug monitoring and to ensure compliance with medication.

Notable in this decision is the apparent clarity or taken for granted approach with which it is made without reference to the complexity of the terms or issues mentioned. Apart from mentioning the accused’s need for continued support, there is a lack of explanation as to what

this support will entail or why such a need could only occur in the confines of a forensic hospital and not in the community...or at all.

Another example in Re SG, the Board states “the accused is currently diagnosed as having undifferentiated type schizophrenia” with no other qualification. One might wish, from an ethics point of view, not to assume how particular disorders are presented or determined, despite how they are delineated out of context in the DSM for example. This would avoid the presumption of a particular representation of categorical diagnosis, rather identified and explicit behaviours and interactions with the accused would be more helpful and indicative of potential problems in behaviour. Simply stating a given diagnosis as evidence towards meeting a particular level of significance for a risk assessment is dubious. Furthermore, the indication of a particular diagnosis is seen as sufficient for subsequent expectations regarding medication compliance, insight and behavioural prognosis.

Indeed, as a case example, in Re WM the dissenting opinions identify a more complex array of issues than the majority opinion, arguing that rather than the majority disposition of detention order on a medium secure ward, the accused could be managed on a minimum secure ward with the possibility of community living privileges adjudicated by the hospital if deemed necessary.

The majority disposition justification for Re WM is summarized as follows:

He lacks insight into the fact of his illness or the need for treatment with psychotropic medication. In fact, he feels he does not need medication, and in his testimony evidenced no appreciation of the consequences of the commission of the index offences on the victims, focusing only on the deleterious consequences to himself. His risk assessment

scores are in the moderate to high range. He has been diagnosed with personality disorder not otherwise specified, and exhibits narcissistic and antisocial personality traits.

The minority opinion, in arguing for an order of a stay on a lower security psychiatric unit with a community provision, states that “this provision however and its actual administration would not obligate the hospital to place WM in the community during the next twelve months. This would nevertheless allow the initial planning stages of community living to begin if WM demonstrated improvement in his insight into his mental illness”.

The minority opinion subsequently states that the accused suffers from “an Axis II Personality Disorder, not otherwise specified, with narcissistic, antisocial and dependent traits. This view is unanimously held. This presents a difficulty with insight”.

Unlike in the majority decision, the minority then try to define, although in a limited way, what would constitute an improvement in insight, stating that insight would be “related to an understanding by WM that he does indeed have a mental illness, that he needs ongoing treatment...Unless he has insight into the need to willingly cooperate with treatment, it is doubtful the risk will ever be diminished sufficiently for any type of discharge”.

It is still unclear in the case, however, how insight is necessarily measured or applied, yet it is clear that the Board members understand there to be a natural presentation for mental disorders and personality disorders, and that they are seen to necessarily impinge on insight. The issue of a nature of a given disorder is subsequently problematized by the dissenting member of the Board, but this is never touched on by the majority members or more importantly, indicated in any other decision under analysis.

The minority member states “however, since other psychiatrists have disagreed with the diagnosis of schizophrenia, to insist that WM agree with Dr. M’s diagnosis of schizophrenia is

nothing more than a shallow and meaningless exercise which is not in the best interest of the accused, as it could become a grave impediment to progress in his treatment”. This is a uniquely critical opinion across the sample, where the minority member indicates the possibility of variable diagnoses, as well as deconstructs the seemingly infallible evaluations of the attending psychiatrist reporting on the accused. Importantly, a lack of acquiescence to the ascribed schizophrenia diagnosis is seen by the majority members as a lack of insight and a rejection of treatment as a result of the nature of the identified personality disorder. It stands to reason, however, that if one accepts that the initial schizophrenia diagnosis could have been erroneously applied, then the personality disorder may similarly have been erroneously identified. Importantly, the impact of such a disagreement can only be considered if and when there is disagreement between psychiatrists that is documented in a particular report submitted as evidence, otherwise a diagnosis is unilaterally understood as valid. What can become problematic in other instances is that there may not have been historical or varied interactions with mental health professionals, such that differential diagnoses would not be identified. In not being critical of diagnoses, and understanding mental disorders as having an essential nature, the Board is projecting a particular medicalized conception of these disorders, ascribing a biodeterministic model to them despite the complexity in determining, treating and describing particular mental disorders as discrete entities (BPS, 2011; 2012).

The British Psychological Society as well as the Society for Humanistic Psychology, a division of the American Psychological Association, have both indicated reservations with the construct of mental disorder and the preferred treatment regime indicated in the DSM that predominantly indicates the use of psychotropic medications (BPS, 2011; 2012; Robbins, 2011). Robbins (2011) argues that advances in neuroscience and psychophysiology have ultimately

failed to indicate a single biological marker that can reliably substantiate a given DSM diagnostic category. Thus a conceptualization of mental disorder as entirely or mostly accounted for by a biological and thus “natural” iteration may have particular ramifications scientifically, in terms of what research is considered relevant and valid, as well as socioeconomic and forensic consequences in how individuals ascribed a given disorder are identified in the legal and psychiatric systems, how their behaviour is understood and measured, and ultimately whether or not they can receive treatment and what kinds of interventions can be applied (Robbins, 2011). Additionally, in describing mental disorders as biologically confirmable and natural (natural in their presentation, not necessarily ‘normal’), the use of psychotropic medications is justified. Robbins (2011, para. 27) argues, however, that “growing evidence suggests that though psychotropic medications do not necessarily correct putative chemical imbalances, they do pose substantial iatrogenic hazards. For example...neuroleptic (antipsychotic) medications, though helpful for many people in the short term, pose the long-term risks of obesity, diabetes, movement disorders, cognitive decline, worsening of psychotic symptoms, reduction in brain volume, and shortened lifespan”.

Similarly, the British Psychological Society (2011) argues against the use of discrete, categorical diagnoses of mental disorder, suggesting that mental disorders are best explored as part of a spectrum shared with so-called normality. The Society (2011, p. 3) ultimately argues that the purported benefits that some individuals might enjoy from receiving a particular diagnosis in terms of being validated, justified and explained in some fashion, are in fact a “spurious promise of such benefits. Since, for example, two people with a diagnosis of ‘schizophrenia’ or ‘personality disorder’ may possess no two symptoms in common, it is difficult to see what communicative benefit is served by using these diagnoses.” Ultimately, it is argued

that an individual description of behaviour and an individual's own perceived problems, if any, are more relevant to predicting treatment response than a given diagnosis.

The minority member continues, stating:

Upon hearing the evidence of the hospital, one was struck with the sense that WM was being recommended for a medium secure detention disposition not because of hard evidence of an unmanageable risk in minimum but because of his bad attitude towards and tenuous engagement with the treatment team and his total lack of insight into the diagnosis of schizophrenia...It was equally disturbing that now after nine years under the Review Board, Dr. M stated that WM could have a treatment resistant psychosis in conjunction with personality factors and that he hopes this will be sorted out in 2010. The basis of this resistant psychosis is what was called fixed persecutory delusions that persist. However, it was clear from the hospital evidence that the former grandiose delusions were not fixed as the accused no longer held to them.

The inconsistency in evaluating the patient over time is indicative of an underlying complexity and uncertainty in treating mental illness. Importantly, rejections of treatment decisions and ascribed diagnoses are considered in light of a mental disorder, such that the individual found NCRMD is always evaluated against the listed symptoms for their particular disorder. In this case, a rejection of treatment and a failure to acknowledge the presence of a severe mental disorder is understood as indicative of a lack of insight associated with essential aspects of both schizophrenia and antisocial personality disorder. The fact that there has been a history of differential diagnoses is not considered valid in as much as the current treating psychiatrist would understand their diagnostics to be accurate. The difficulty here is with professional and personal appraisals, as well as secondary risk-management, wherein a

professional, concerned about negative reputation and accountability in light of a possible false negative, would be inclined to conclude their diagnosis is correct regardless of prior differential understandings of the individual's behaviour (Power, 2004). Similarly, this is indicative of a particular psychiatric project that seeks to foster a certain self-monitoring through the identification of "natural or intrinsic" disorders that are seen to compromise the autonomy of the individual. In this way, individuals are rendered understandable and manageable in light of an illness- and risk-based psychiatric etymology.

In case Re KK the Board states "The diagnosis is that of Schizoaffective Disorder. Unfortunately the accused discontinued medication on their own prior to the index offences which led to the severe psychotic state evident at the time". It is interesting to note once more that the Board indicates a direct causal relation between medication compliance and criminality, and suggests in simply naming the diagnosis ascribed to the accused that this particular disorder would similarly necessarily lead to criminality if left untreated in this particular fashion. The persistence in time of the presumption that a given diagnosis would lead to a familiar set of behaviours fails to take into consideration critiques of the presumptions regarding the nature of a given diagnosis and the presumed symptomatology associated with it. Given the artificially constructed categorization of disorders for the benefit of ease of use of the DSM, particular symptoms, behaviour and their persistence over time are not necessarily valid empirically (BPS, 2011; Robbins, 2011). The persistence in time of the association between a given diagnosis and a presumed propensity for directed criminal activity requires clarification on the part of the Board in constructing its rationale for decision. Otherwise it could be seen as a form of hegemonic discourse to the extent that it rejects opposing conceptualizations of disease and normativity more broadly.

Similarly, the Board states in Re JB that the accused is “able to make the connection between his mental illness and the index offence”. Again, it is apparent that the Board requires a particular understanding of the nature of the accused’s mental illness and its causal relation to their offence in order to accept a reduced risk profile. The continued labelling of the accused with an apparently incontestable diagnosis and its application without qualification indicates an overt acceptance of a particular biomedical psychiatric system in which the individual’s frame of reference is only of secondary importance.

In Re SCK, the Board references the accused’s mental condition and apparently satisfactory insight, but suggests that due to the chronic nature of the illness, the accused requires external support as a mediator of the risk posed by a chronic illness. The Board wrote “The risk he poses is from psychosis, but he is stable on medication, with good insight. The breakthrough symptoms are not seen as being unusual nor as indicating ‘fragility’... The accused will be ill for life. However, his risk can be managed in the community where good support is available.” Of note here is that the Board itself has placed the term “fragility” in quotations, but fails to operationalize the term, taking it at face value as a submission from the expert psychiatrist giving testimony. In operationalizing terms, the Board should seek to identify how and why it has accepted and applied particular expert testimony. Indeed, as mentioned above in the section describing the notion of insight, the Board conflates terms and interprets them differently as indicated by dissenting opinions. Therefore, it is essential for the Board, rather than smoothing out apparent undulations in determining a disposition, to acknowledge uncertainty and disagreement and explicitly identify in its rationale the interpretation and application of particular exhibits. Additionally, the Board says that the accused will be ill for life, identifying a certain deterministic essentialism for the model of disease of the accused.

In Re BLA, the Board further comments on the nature of mental illness, writing:

Having heard and considered all of the evidence adduced and the submissions of all of the parties, the Board had no difficulty arriving at the unanimous conclusion that BLA continues to meet the test of posing a significant risk to the safety of the public. BLA has a lengthy history of suffering from a major mental illness, currently diagnosed as schizophrenia. He also carries a diagnosis of anti-social personality traits and his prorated score of 29 on the PCL-R places him just below the cut off for psychopathy...The nature of BLA's mental illness is such that he tends to decompensate relatively quickly when non-compliant with medication...As of the date of the hearing, BLA remained acutely psychotic which, given his history, placed him at very high risk for unprovoked, aggressive behaviour. As a result, the test for significant risk was met...As noted above, as of the date of the hearing BLA remained acutely psychotic, far beyond his residual psychotic baseline.

The above case is discursively loaded as it makes mention of multiple diagnoses, an assessment of psychopathy that does not meet the accepted threshold based on the PCL-R assessment tool used as an apparently objective test for psychopathy, as well as it comments on the "true nature" of the accused's illness. Of significance is a reference once more to the nature of disease requiring total compliance in order to mitigate risk in terms of the risk of "decompensation". The lack of explanation regarding the terms used and the potential ramifications of labelling the potential for life-long decompensation are left unsaid, under the presumed idea there is total accord amongst the individuals involved.

The Board similarly refers to an essentialist nature of disease in Re CJ where it states:

It is clear that CJ's insight into the wrongness of his actions is not full. Dr. S explained that it is in the nature of Schizophrenia to attack insight. But CJ knows that they led to his arrest and Board dispositions. Currently, he denies any intent to act this way in future; rather, if such a situation were to arise again, CJ would seek help from the authorities.

The statement on the essential nature of schizophrenia is problematic insofar as it is not unilaterally defined or presented. Importantly, when combined with the suggestion that an accused will be ill for life, and their insight continually under attack, it suggests the continued need for the management of risk from the hospital and the community, so as to waylay such a risk. There is an incongruent conceptualization in the ontological commitment of the Board in determining the limits and capacities of an individual diagnosed with a mental disorder. The diagnosis is seen to realize a particular disorder that ultimately attacks insight and reasoning, but through particular interventions and manipulations by a psychiatric expert and the use of psychotropics, the individual is considered capable of self-control and self-management when that management is in line with a particular normative ideal outlined by that psychiatric expert and the overlying project. How is one to consider the self-actualization of an individual who is either incapable of sound reasoning due to a mental disorder, or who is only capable of sound reasoning and personal agency when that agency is constrained to a particular politics of behaviour.

In one final case Re JN, the Board renders a detention disposition for an individual adjudicated as NCRMD based on a failure to comply with a recognizance, stating:

Her behaviour has been described variously as aggressive, intrusive, and distressing to co-patients on her ward, to staff and to members of her own family. She has had to have been placed in seclusion on a number of occasions due to her aggressive and intrusive

actions on the ward. In the opinion of the treatment team, to a medical certainty, the accused places herself at risk for physical harm and causes psychological harm to those around her...She is in a floridly psychotic state and in the words of Dr. C. "may be in a place psychiatrically where she has never been before".

In describing their disposition and the case in general, the Board references the behaviour of the accused as aggressive, intrusive and distressing. However, authors critical of the positivist and medicalized understanding of disorder argue that depictions of patient aggression are often made from a single vantage point – the observations of hospital staff – who may be overly attuned to particular behaviours as being aggressive in such a way that they would be harmful to an individual (Benson et al., 2003; Horsfall & Cleary, 2000). Furthermore, the accused or the patient rarely if ever has the ability to offer their view of what happened, wherein the potential for miscommunication and misinterpretation of intent and behaviour from all parties could involve different conceptions of the event. The one conception held above the others is that of the attending expert observing the individual (Benson et al., 2003; Horsfall & Cleary, 2000). Further, the Board accepts the opinion of the treatment team that there is a “medical certainty” that the accused is at risk for physical and psychological harm to themselves and others. Of significance here is that in no assessment or positivist research is a causal relationship identified between specific factors or criterion and risk. To the extent that risk is already constituted as a probative conception of possible outcomes, the depiction of a medical certainty of risk is misleading, but lends credence to the notion of an increased risk profile from the apparently disturbing behaviours of the accused.

A Brief History of Time: The Temporal Factor

In Re JD the majority members determined that the accused does not represent a significant risk to the safety of the public and determined an absolute discharge would be appropriate, stating “in coming to the position of an absolute discharge, the majority of the Board accepted the evidence of Dr. B pertaining to the Accused's insight into the index offence and his remorse, his insight into his mental illness and his understanding of the importance of taking his medication”. The dissenting opinion in the case, however, argued:

JD has continued to have negative symptoms as recently as four months ago with lack of motivation and apathy and having spent the summer of 2013 watching television and playing video games. It is only since September 2013, that he restarted taking one Grade 10 credit attending school in the afternoon only, and began volunteering at Habitat for Humanity one to two times per week.

Ultimately, the minority states “the risk for future relapse is inherent in the nature of the illness from which JD suffers”.

The dissenting opinion argues that the chronic nature of the mental illness of the accused represents an inherent risk, thus it is difficult to ascertain how this risk could be adequately reduced, if it all. As evidence of the problematic nature of the mental illness are the apparent negative symptoms indicating a lack of productive pro-social behaviour. It is unclear how these behavioural elements on their own would constitute a significant risk to the safety of the public, beyond being a possible nuisance problem. In concert with the above problematized notion of a natural presentation of disorders, the dissenting opinion disagrees with the absolute discharge disposition of the majority members due to the recentness of apparently negative symptoms.

Temporality, or the element of time and its importance in making a determination of risk, is a common element in dissenting opinions. Clearly, as the notion of risk is a predictor of potential harm over time, a temporal element might be expected to be present in a disposition decision. The issue, however, is that it is a common source of contention, suggesting the members of the Board are not universally agreeing to or applying temporal factors as a relevant factor in mitigating or aggravating an accused's level of risk. The issue of temporality is present in both majority and dissenting opinions, and can be related fairly overtly, in the sense of specific time periods, for example suggesting a lengthier period of time would provide the treating hospital more time to evaluate the accused, or less overtly in discussion of decompensation or stability of illness. In either case, it can be seen as problematic because there is a lack of determinacy to the proposed time periods. Rather, they appear to be arbitrarily applied based on individual conceptions of the rate of decompensation, the capabilities and mechanisms of action of varied neuroleptics, and an assumed standardized model under which these treatment regimes can be applied to categorical diagnoses.

For example, in *Re JS*, a dissenting member of the Board arguing against the absolute discharge disposition of the majority, states:

A Conditional Discharge over a lengthier period of time would provide the Team to observe how JD responds to life stressors. The long-term course of his illness remains to some extent unknown...A positive response to treatment, mostly within the past two years, while encouraging, is not necessarily determinative with respect to the long-term prognosis. The risk of future relapse is inherent in the nature of the illness from which JD suffers.

The proposal to maintain the accused on a conditional discharge order in order to continue to evaluate their behaviour under the pretence that the long-term course of their illness is unknown is representative of a systemic containment of risk – by extending the length of time an individual is under the purview of the Board and subsequently a treatment team, it extends the length of time that a particular psychiatric project can work to inculcate specific management techniques meant to mitigate the risk posed by the accused. This of course comes at the expense of the accused's liberty. Importantly, in referencing the long-term course of an illness as remaining unknown, suggests that the long-term course of an illness is capable of being known, quantified, and understood. The implication is that psychiatry as a discipline is capable of understanding and not only predicting, but determining the life-course of an illness and subsequently the individual ascribed that illness.

In another exemplar case, *Re JB*, a member dissented to a particular condition on an order allowing for the accused to go on a 48 hour pass to a cottage with an approved person. The dissenting opinion says “upon admission to hospital initially only 3 years ago, it took a full 8 months to stabilize JB adequately so that treatment could begin to be effective...JB has a history of rapid decompensation.” The board fails to identify what rapid decompensation suggests, or what adequate stability entails. Is 3 years considered a short amount of time to stabilize and treat someone, and if so, what does this suggest about the state of affairs for the profession and its ability to treat people if 3 years is considered a short amount of time for institutionalization? Indeed, it suggests that in terms of professional conduct and the mitigation of secondary risk, temporal elements are significant in justifying a decision made to limit an accused's liberty in light of a possible, not probable, risk. Stability in this sense also requires operationalization because it fails to delimit behaviour in terms of stability. What is considered stable, and what is

stability in light of medication effectiveness, given that psychotropic medications are intended to stabilize apparently aberrant behaviour?

Finally, in *Re RDA* the dissenting member of the board suggests that the accused should be kept in a medium secure environment rather than being progressed to a minimum security ward. The justification tendered is that they would like to see a “pattern of behaviour tested in a medium secure environment” including “gradual increasing of RDA’s and a continued monitoring of his clinical stability prior to moving RDA to a minimum secure ward”. Similar to the previous case, a pattern of behaviour is not defined, nor is it acknowledged the difficulty in exhibiting a pattern of behaviour indicative of stability when all behaviour is necessarily viewed in light of an ascribed illness. For example, issues of aggression are magnified when identified in an institution, as well as in light of the carefully controlled environment in which forensic hospitalization occurs, any behaviour outside the limited acceptable realm occurs in stark contrast.

Conclusion

In interpreting the dispositions of the Ontario review board, the notion of a medicalized certainty in their dispositions renders the decisions and conceptualizations of disparate behaviour and reports about the accused as objective analyses. It becomes a system whereby expert frames of knowledge are reified by the very conditions they seek to identify and classify through investigation and classification.

Therefore, the objectivity-effect, whereby the observation and conceptualization of psychiatric experts are standardized and made universal, renders particular phenomena as more scientific or formal than they were previously conceived. Thus, the intractability of mental illness, and the multitude of factors underlying conceptions of behavioural risk, are occluded

through the notion of “black-boxing”. Black-boxing occurs where the complex array of judgments and decisions that go into an assessment are rendered incontestable and “objectified” (Hopwood, 1988; Latour, 1987). Thus, an immutable, objective evaluation of risk replaces the constructed and negotiated relations between expert and accused. A black-box originates from systems theory and describes a system that can only be viewed in terms of its inputs and outputs, but without any understanding of the processes of its implementation. In this way, justification process of the review board is termed a black box insofar as its output, the terms used to justify a given risk profile and disposition, obfuscate a preponderance of evidence, conceptualizations, personal understandings, values and interpretations that coalesce between the transfer of evidence and practice and the output as documented in the rationale for decision.

Insight, compliance and references to particular disorders are a reduction in complexity faced by the review board in order to establish a more credible evaluation of behavioural risk. Thus the usual complexities surrounding a disposition of the liberty of an individual are displaced by formalized, pseudo-transparent discourse that can be justified in the future if required. As Rose (1998) states, “the 'objectivity effect' of professional claims...increases its capacity to accrue conviction in a climate of doubt and criticism from those outside the field of knowledge itself. It is to help sustain the bureaucratic and political assertion of the mental health professional that, potentially at least, they have the capacity to make objective, impersonal and unbiased assessments.” (p. 181).

The board has ultimately reduced the complexity of the notion of insight, and indeed the notion of risk. Insight is reduced essentially to an evaluation of the need to take medications to treat a given disorder, and in so doing the Board has also reduced the notion of criminogenic risk to essentially the same thing. Similarly, the notion of intervention and the possible schema for

successful psychiatric treatment are reduced to a biomedical understanding of psychiatry and the need to take psychotropics and neuroleptics. The intervention's main goal is no longer to provide a cure, nor to elaborate a holistic treatment plan, but to simply make sure that the prescribed medications are taken and that criminogenic risks are thus being managed. An analysis of risk, and all that might constitute and coalesce to construct the notion of risk, is reduced to a particular medicalized psychiatric rationalization.

In a legislative sense, the issue of black-boxing and objectivity is relevant here insofar as the prior conception of Not Guilty by Reason of Insanity was considered a violation of the Canadian Charter of Rights and Freedoms because accused were arbitrarily detained based on unspecific criteria used to determine whether their detention was warranted (Grantham, 2014). Importantly, if it can be understood that current decisions are rendered intelligible only through the use of terms that reduce the complexity of dispositions to apparently objective criteria, the potential policy and legislative ramifications would be important to investigate in the interests of constructing an ethical and balanced system of judicial decision-making.

The Administration of Risk

The second predominant theme present in the cases under study is that of the administration of risk. The administration of risk, however, is conceptualized in the sense of coordinating and managing the movement of individuals considered risky or at risk across an archipelago of professional, government-sponsored, semi-private, and private psychiatric agencies, while concurrently managing their proposed risk across social institutions: the family and peers, occupation, and education. Additionally, under the dominant theme of the administration of risk, another subtheme is discussed with regard to the evidentiary standards upheld by the review boards, citing consistently that they are basing their decision on the hospital report and the testimony of the attending forensic psychiatrist in the hospital. Finally, a subtheme related to evidentiary standards and expectancies in delegating risk and the role of managing risk through dispositions and the use of actuarial risk assessment is considered since it is mentioned consistently as a primary factor in the review of the literature, but curious in its absence from the majority of dispositions. This process of administering risk across networked systems of control indicates a reification of the system of discourse in which the opinion and assessment of a particular discipline is held above others, in a top-down approach to knowledge construction and the assessment of risk. This ultimately has ramifications for those under the purview of the review board to the extent that their liberty is tied into these assessments and their presentation.

Professional Supports

As discussed above, according to various theorists the extension and transmutation of psychiatry itself from the strict boundaries of the asylum to a more diffuse presentation amongst the community allows for particular systems of control and coercion to come into play. Psychiatry takes on more of an administrative role rather than a strictly clinical one, managing

individuals across the multiplicity of social institutions proffering mental health services within the community.

In cases where an absolute discharge is being considered the Board often refers to whether or not the accused has access to professional resources and supports in the community in order to justify their disposition of an absolute discharge. Importantly, the notion of the potential for decompensation in the accused is considered a significant risk factor. The risk of harm is not located simply in their proposed propensity for violent recidivism, but rather in a sequence of events, like a chain of causation, from the risk of treatment non-compliance, to decompensation and a return of psychosis, to a violent act causing significant harm. Thus, while the appraisal of future significant harm suggests an apparently stringent test, the elements composing that test are significantly less onerous. In this way, the attending psychiatrist and the Board are implicated in conducting more onerous assessments of risk due to the potential for being held to account publicly for false negatives. In a position where a disposition is made to release an accused into the community, the risk assessment may be used not so much on the basis of accurate predictions, but rather to ensure that the professionals making the decision can justify it should a false negative assessment occur, that is, should an accused recidivate (Rose, 1996).

Furthermore, as risk has become diffuse in the community, spread across varying agencies of control in different ways, Rose (1996) describes how experts now have an “obligation to take responsibility for the calculations that they make, the advice that they give and the success of the strategies that they put into place to monitor and manage that risk” (p.349). In this way, a reciprocal risk management is placed on the experts themselves to coordinate their efforts to ensure accurate predictions of risk by conducting more onerous and cautious dispositions. Thus, the Board and forensic hospital are essentially able to transfer

custody of the accused to community agencies offering similar structuration and treatment plans for the accused, in order to waylay the possibility of false negatives, transferring it to other agencies, in a form of secondary risk management. Secondary risk management, recalling the section *On the Nature of Diagnosis*, occurs when a professional, concerned about a negative reputation and their own accountability in light of a possible false negative, would be inclined to be more defensive in their decision-making than in an environment not defined by a politic of risk (Power, 2004). In terms of governance, this can be understood in light of responsibilized agencies and agents who must account for their decisions in light of a structured system of knowledge and a particular understanding of behavioural controls and risk-potential.

For example in Re SA, the Board states in reaching a disposition of an absolute discharge, that the accused “has already connected with a family doctor in the community, and he will be supported by the hospital in connecting with a community psychiatrist”. In case Re RDB the Board writes:

He will be under the care of the Link team after discharge...the Mental Health Act would be able to manage the risk in the event of any decompensation. The Board understands from Dr. J’s evidence and MW’s submissions that the hospital will continue to provide care for RDB until his transition to the Link team can be effected.

The Ontario Mental Health Act referred to in this case is a piece of legislation that primarily regulates the involuntary admission of individuals into psychiatric hospitals, as well as legislates issues of treatment and consent to treatment (OHA, 2012). Additionally, the Mental Health Act allows for the disposition of community treatment orders, whereby physicians and psychiatrists can provide comprehensive psychiatric interventions in the community, as opposed to having an individual necessarily institutionalized (OMA, 2012).

LINK teams are similar to, and sometimes interchangeable with, Assertive Community Treatment Teams (ACT Teams) (LINK Team, n.d.; CMHA, n.d.). These are multidisciplinary teams of mental health professionals, although always including a psychiatrist, that provide treatment support services to individuals in the community. ACT Teams are community centered agencies for those with severe mental illness who “require ongoing, comprehensive and individualized mental health services...the team works in partnership with their clients to decrease the need for hospitalization and improve the client’s quality of life.” (Trillium Health Partners, n.d., “ACCT”). The team also provides treatment and medication monitoring and ongoing assessment of mental health concerns. ACT teams work closely with other care providers including family physicians, drop-ins, staff from supportive housing, and inpatient teams to monitor and provide care to their clients.

The Board refers to the inclusion of ACT teams in several cases. However, as mentioned in the introduction to the results and discussion, a source of dissention identified in the Board relates to an understanding of professional trust and the abrogation of roles and responsibility. In terms of external professional supports such as ACT teams, one dissenting case illustrates a potential lack of confidence in delegating authority over the individual from the remit of the Board to a professional support structure.

In case Re JH, the dissenting member states:

I am unable to distinguish between the situation at last year's hearing and that before the Board on this occasion. There has been no withdrawal of the Outreach team's support for JH and a transition to community supports in order to test his ability to function in the community. The evidence of Dr. B is that JH has been accepted by the ACT team. As of the date of the hearing no further steps have been taken in respect of that transition. Dr. B

stated that the ACT team are reluctant to duplicate services while an accused is under the authority of the Ontario Review Board and therefore no further transition will take place until the absolute discharge is granted. While I understand the need to make the most effective use of the scarce resources available to the mental health professionals working in this area, I do not agree that the Board should surrender responsibility for an accused to the community on the basis that the ACT team have agreed to work with JH... until there has been a demonstrated connection between JH and the ACT team and the gradual withdrawal of support by the Outreach team, community safety can only be assured by the continuation of the current Disposition order.

The dissenting member argues for duplication in services between the external ACT team and the Outreach Team. The Outreach team is essentially a forensic psychiatric service that maintains surveillance, management and risk assessment duties of the NCRMD individual once discharged to the community. Ultimately the Outreach team links individuals with a community-driven on-going support team like an ACT Team or group home in order to accommodate the individual in the community if/when they are absolutely discharged. The liberty interests of the accused, while ultimately they are absolutely discharged, are undermined in this case by the dissenting opinion which will not act first to extend professional trust toward an external agency in order to benefit the individual found NCRMD. If the limiting factor for the dissenting member is simply a more robust connection between the accused and the ACT team, it is difficult to consider the need to maintain the individual under a disposition order. The issue of professional closure and risk will be detailed in depth below; however it is evident that at least in some cases, secondary risk management directly conflicts with the liberty interests of the accused.

The use of ACT teams and other external professional supports is relatively common, especially with regard to justifying an absolute discharge or not. For example, in Re JD the Board states that the accused “would be followed in the community by the Canadian Mental Health Association Transition Case Manager, the Outreach Team, and the attending psychiatrist until he obtains a Psychiatrist in the community. JD has also been referred to the Guelph Act Team.” In another case, Re. SG the Board writes “as long as SG continues with the ACT team, there is no real chance of non-compliance and without non-compliance there is no significant risk.” In yet another case, Re JH the Board writes “he has a family doctor, a registered nurse, a podiatrist and a dietician on service in the community...JH is compliant and cooperative with the treatment team. He accepts and recognizes his need for support. He has indicated a desire to continue with the supports that have been afforded to him.” In an absolute discharge Re SP the Board writes in their rationale:

He is well engaged with his treatment team and now has a treating psychiatrist with who he enjoys an excellent therapeutic relationship. We fully anticipate that SP will continue to rely upon his psychiatrist and the team and obtain their assistance, as he has done in the past.

In this case, the Board is explicitly encouraging the accused’s continued reliance on the treatment team rather than establishing autonomy and agency of self. Similarly, in transferring responsibility over the accused’s management of risk, in Re JX the Board writes:

He clearly requires close and careful monitoring and support, and that will continue through the PROACT Team, which is now prepared to assume responsibility for JX’s care. We do agree with the evidence that the accused requires ongoing close and careful monitoring, but on the plan put forward by Dr. E through the PROACT Team, this care

will be provided without the accused being subject to the Disposition of the Ontario Review Board.

Having connections, either through the accused's own network, or through the resources and networks of the hospital they are kept in, is considered encouraging to the Board in reducing the risk level of the accused, or at least the risk the accused poses to the reputation of the Board. On the other hand, a lack of professional community supports is considered an aggravating risk factor for the accused, in conjunction with their actual conduct, insight or medication compliance. None of these factors are necessarily contingent for a particular disposition, but they can at any one time be considered sufficient for negating an absolute discharge. Of significance as well is that the forensic hospital and treatment team is supposed to provide networking and connections to these community treatment organizations, such that it is ultimately on the psychiatric team to establish these supports, yet it is held against the accused in the event that they do not have these supports established. For example, the Board states in *Re JJ* that "it is observed that the accused does not engage well with team members and only seeks assistance with very practical matters. It is predicted that he might be difficult to engage in future psychosocial intervention." This has been discussed previously in light of a psychiatric project promoting self-regulation and the inculcation of psychosocial intervention (Rose, 1991b). Maintenance and development of the psychiatric project become problematic, however, because the system of knowledge acquisition it is based on and its underlying epistemology is intrinsically tied to and confounded by political institutions in the social world (Rose, 1991). The way we define the concept of intervention is critically related to the concepts of psychology and governmentality that are defined and constituted by those in power. Our systems of knowledge, including the psy-disciplines and the knowledge of the self that they purport to know and

understand, become systems of production rather than investigation, such that our concept of what it means to be a productive or actuated individual are defined by these pre-established knowledge systems (Rose, 1991b; Cruikshank, 1993). Ultimately, risk is considered in light of this productive ideal, rather than explicitly with regard to the potential for violent recidivism.

Therefore, an accused is considered at higher risk if their professional networks and relations do not run in tandem with those espoused by the Board. In fact, the Board notes the possible difficulty in engaging the accused in psychosocial intervention as a risk on its own – regardless of other factors, the possible rejection of professional discourse, ideology and practice is considered a risk to the posterity of the forensic psychiatric system coupled with the legal system.

In re JK the Board writes:

It remains early days for JK and his reintegration into the community...which is best done with the support of the treatment team and the various caregivers who are available to assist JK to this regard. It is somewhat concerning that virtually without reason and on short notice JK decided to not attend the Salvation Army program which the treatment team had assisted him with and which appears to have formed part of the discharge planning for him. The doctor raised concerns that JK while residing in the family home might well not attend programs such as this.

Similarly, in Re WM in evaluating the need for a high level of professional structure that apparently cannot be delivered by the community treatment agencies, the Board cites “his need for a high level of structure and supervision in daily living; and the fact that he feels that he does not suffer from a mental illness, and therefore lacks insight into his present condition.” Thus there is a constellation of factors that underlie the assessment of an accused’s capacity to be

managed in the community – one who acknowledges their illness and accepts the need for medication compliance, while welcoming continuous support and surveillance from mental health agencies in the community.

In other cases, the assessment of risk occurs as quotidian, insofar as disposition decisions are made based on securing specific levels of risk within a detention order or a conditional discharge, assessing the need for various security levels. For example, in *Re PD* the Board states “the hospital needs to have the discretion to return the accused to the hospital if he begins to show signs of decompensation. This return could not be accomplished under the provisions of the Mental Health Act.” In another case, *Re RDA*, “[taking into consideration] that he has participated in programming, that he has been open with the treatment team...The Board is satisfied that RDA will have access to similar programs on the minimum secure unit”, in another case, *Re WM*, a disposition decision hinges on the following “his need for a high level of structure and supervision in daily living.”

Significantly, the legislation underlying the review boards states that if an absolute discharge is conferred, then the review board will have no jurisdiction over the accused. Yet, in the cases above, an absolute disposition or even dispositions into specific security levels within a hospital, are constructed based on the level of external professional support able to manage and observe the accused. Where an absolute discharge is considered, risk itself is tied into whether or not the accused can continuously be monitored in the community, not whether or not the accused has demonstrated the ability to self-manage or at least avoid recidivating. Thus, the Board seeks to ensure that particular psychological agencies are available to support and render the accused manageable in the community as transference of custody under a therapeutic lens. This is perhaps most representative of Szasz’s (2004) argument that elements of social control made to

seem therapeutic are perversions of social ordering and therapy. The argument is based on the notion that particular psychiatric regimes understood to be therapeutic are used to treat individuals “for their own good”, regardless of any pejorative effect. In this case, a reduction in the liberty interests of the accused.

Lay Supports

The Board, while aligning its conceptualization of risk with the inclusion of professional psychiatric agencies and support programs in the community, also forges links between the risk of significant harm and the presence or absence of non-professional supports in the family, work, and education. In proposing the need for these, it provides an opportunity for continued surveillance efforts in the community through the inculcation of the need to manage risk to themselves and of those in the community. The Board can parlay community relationships, responsabilizing them with the care and observation of individuals legislatively required to be discharged. However, under the professional discourse of psychiatry, they are ever more amenable to management and monitoring upon release from institutionalization.

Family Supports and Relationships

In Re SA the Board states in their reasoning for conferring an absolute discharge, that “it was noted that when non-compliant, deterioration was gradual. Given the level of support and the accused’s regret for the index offence, adequate safeguards were in place without a detention order.” The Board goes on to identify exactly what it is meant by “the level of support” that represents an adequate safeguard to the significant risk of harm arising from the accused’s mental disorder. The Board states that the accused “enjoys a strong family support system...his father has offered feedback to the forensic outpatient team given his close relationship with SA at work and at home...SA continues to benefit from a strong support network within his family.”

Thus the board is outlining the importance of the family unit as a support system for delegation of risk management and surveillance. The Board continues, writing that the accused's father "has good awareness and insight and has proven reliable in reporting any fluctuation." Thus the accused's family member is in fact encouraged and prompted to directly manage the risk posed by the accused through continued surveillance and reporting to the forensic outpatient team overseeing the accused. The systemic reach of the Board is widened from assessing character traits of the accused to include assessing those of their relatives or peer group as potential agents of surveillance and guarantors of risk. In a similar vein in Re RDB, the Board writes that although the accused has "limited contacts in the community, RDB is not a significant threat for that reason alone. He lives in a rooming house and works with others; he has regular contact with his sister, who is aware of his illness." Once more, the Board is acknowledging the importance of lay persons in the community taking on the role of management and surveillance of the potential risk subjects in their community, in line with a neoliberal ideology. Once more, in Re JD the Board states "we have also taken into account the evidence that his parents understand his illness and would seek help in the community, if necessary."

In other cases, the notion of family and social engagement is a primary concern for the Board in establishing a risk profile of the accused. Rather than overtly identifying the advantage of having a family member capable of managing and reporting symptoms, these social relationships are presented as therapeutic for the accused. In Re SP the Board states "the accused is engaged in employment and in recreation, albeit, there is room for improvement in his social engagement with others." In Re LV the Board writes that the accused "has been married for the past 21 years. There are two children; LV is extremely involved with the children and all of their activities. There are other family members living in the same household." The implication

apparently being that close-knit families and considered involvement with one's children are mitigating factors in assessing risk. In another case, Re SCK, the Board states that the accused's "recent move to their own accommodation and lack of family support" are indicative of potential risk, however they follow this saying "however, his risk can be managed in the community where good support is available." Once more, the importance of community ties is iterated by the Board.

In a one off statement by the Board in Re SG, they straddle the line between the promotion of particular prosocial behaviour and their encouragement of filling the accused's time to a degree that they are unable to decompensate or consider different treatment options, stating that the accused "has worked hard at his job, sometimes working six days per week and in fact working to the point of exhaustion, to occupy his otherwise very isolated life... The facts that SG is not a good communicator and is isolative are not qualities that should stand in the way of an attempt to arrive at the correct conclusion about his future". Portrayed somewhat uniquely as a mitigating risk factor, the accused's social exclusion through an exhaustive work ethic can be considered a form of self-regulation in line with the risk avoidance understood as essential by the Board.

Education/Occupation

That the Board mentions the accused's occupation, education or recreational activities as structuring components of their lives is seen throughout the cases under study. In various cases, the Board references occupation and education as important factors in the mitigation of risk:

He continues to work full-time; his return to full-time work has been successful; held full-time employment; continues to function in the community working part-time at the

Library; he has been rapidly completing necessary education to attain accreditation in the field of auto mechanics.

Interestingly, the preceding were from absolute discharge cases, while in detention dispositions, there are only two brief references to occupation and school. This could simply be due to the ladder disposition levels from detention, to conditional discharge, to absolute discharge, as the accused simply has more opportunity for social engagement and occupation once they are nearing the point of receiving an absolute discharge. Ultimately, the importance of acquiring a job or committing to going to school is an important element in an accused receiving an absolute discharge, suggesting it would be more difficult to go directly from a detention decision to an absolute discharge without following the strictly tiered approach. In fact, the accused population in Ontario observes lower attendant rates of movement from detention directly to absolute discharge than in other provinces. Rather, they are seen to progress through the three tiered approach in the majority of cases where an accused is eventually absolutely discharged (Crocker et al., 2015a).

Economic Dependence

In establishing an apparently beneficial independence concomitant with a reliance on the support of professional and lay agencies, the Board values occupational, educational and residential factors in assessing the risk that the accused poses. Under the so-called standard view of assessing risk, these dynamic risk factors are essential in mitigating risk insofar as having a job, schooling, and appropriate accommodations are seen as structuring forces for an individual, as part of prosocial behaviour (Hannah-Moffat, 2005). It also represents, in light of a neoliberal understanding of productivity and community agency, acquiescence to a particular way of living and ethics of behaviour. In this context, financial independence and thus protection against

economic instability is seen as important for the accused to establish in order to receive consideration for an absolute discharge. In Re RDB the Board states that in reaching an absolute discharge, one of the factors mitigating the accused's risk is that they "recently assumed financial responsibility for their medication, albeit he would rather not pay...RDB also took a step toward managing his treatment by assuming financial responsibility for his medication this spring."

Therefore, not only are accused expected to acquiesce to treatment decisions, they must also apparently welcome the "liberating" aspect of paying for that treatment. In Re AL the board states that the accused "has always taken his medication, and has indicated his intention to continue taking it and to pay for it". In this way, the accused can be depended on to manage the more quotidian aspects of their lives, protecting themselves and the community from possible deviant or delinquent behaviour, criminal or not. In this sense, accused are depended on by the Board to become financially independent in order to demonstrate acquiescence to the neoliberal form of governance structuring the discursive plane of the mental health review board and psychiatry generally. Interestingly, according to the National Trajectory Project conducted in 2015, 67% of NCRMD accused were receiving governmental income support, and 5% were homeless, suggesting a lack of economic stability amongst the NCRMD population, indicating a near universal aggravating factor in the assessment of risk to a larger social ethics of behaviour (2015b).

A Confusion of Tongues: Evidentiary Standards for Assessing Risk

Under the dominant theme of the administration of risk is a final subtheme focused upon the evidentiary standards upheld by the review boards. Citing consistently that they are basing their decision on the hospital report and the testimony of the attending forensic psychiatrist in the

hospital, the Board develops a reification of the system of discourse insofar as the opinion and assessment of a particular discipline is held above others, in a top-down approach to knowledge construction and the assessment of risk. This ultimately has ramifications for those under the purview of the review boards since their liberty is tied to what these assessments communicate about them. In contrast to the evidentiary primacy given to the hospital report and staff, the dissenting opinion in some cases highlight a possible confusion of tongues, as it were, where the origin of the system or agent responsibilized with the control and management of the accused ruptures. A complexity of relations develops between the Board as initial custodian of the management concerns of the accused, the hospital as treatment providers and day to day custodians of the accused physically, and interests on the part of the legal system in terms of upholding the liberty interests of the accused, are seen as competing over who should be accorded primacy of responsibility with regard to the accused.

In justifying the disposition decision made, the Board predominantly refers to the attending psychiatrist overseeing the accused and the related hospital report indicating the accused's recent conduct and development over time as the primary pieces of evidence in assessing their risk. For example, in *Re CC* the Board states that it "accepts the evidence and submission of the hospital"; in *Re CJ* "the expert evidence is that CJ no longer represents a significant risk to the safety of the public"; in *Re KO* "we make this finding on the basis of the evidence of Dr. C and the hospital report"; in *Re JB* "we make this finding based on the evidence of Dr. R and the evidence contained in the Hospital Report"; in *Re GB* "we make this finding based on the evidence of Dr. P." Ultimately, the Board accepts the evidence from the hospital and the report as uncontroverted, thus reifying particular systems of knowledge purporting to know and understand the origins of conduct and thus assess risk within that system.

Thus, the review board hearing process is presented as inquisitorial and holistic, involving all parties including the accused. In reality it relies heavily on the hospital reports (written by clinical staff) and psychiatrists to present evidence as to the capacity of the accused. Within these reports is a particular focus on medicalized notions of conduct, structured observation, and actuarial systems of control. Outside the report, the mental condition of the accused is presented as a particularized medical problem – the notions of insight, compliance and deterioration suggesting a technical understanding of the behaviour and management of the person – yet these are never qualified, defined or associated to any sort of literature, test or other referent; it is a referent in and of itself.

In contrast to the unity observed between the Board and agents of psychiatry, a significant issue identified by several dissenting opinions dealt with the issue of hybrid orders. There existed disagreement concerning the abrogation of roles and responsibility for the management of the NCRMD individual across the parties involved in contributing to management concerns, including the hospital in charge of the accused and the review board itself. Hybrid orders are generally applied to detention orders wherein an individual might straddle the line between two different security thresholds. For example, if an accused is currently housed on a medium secure unit in a hospital but they are considered likely to be able to show improvement in their risk profile through augmented behaviour, insight, compliance, affect or whatnot, then a hybrid order would allow the hospital, and the attending psychiatrist specifically, to move the accused across security levels without requiring the approval of the Board. Typically, in order to change the security level of an accused the hospital must apply for an early hearing with the Board and request the change. Thus, the hybrid order in essence abrogates the responsibility of assessing an individual to the hospital over a finite period.

In Re VD the dissenting member of the board states:

Absent a situation outside of the norm, I believe that it is a core function of the Board to determine the appropriate level of security of those persons under their jurisdiction and that the Board should resist the expediency of a hybrid order and the derogation of the Board's mandated responsibilities...It is unlikely that the hospital has or should be expected to have a high level of confidence regarding VD's trend line over the coming year. Consequently, allowing the hospital to change VD's security level without the Board's direction seems an abdication of the Board's responsibilities, especially when the hospital can request an early hearing if warranted.

The dissent is based on the majority members' disposition ordering a hybrid provision, indicated in part as a possible incentive to the accused to enter treatment programs and remain compliant.

A similar concern is brought up in the following two cases. In Re BK the dissenting opinion states:

These are the Reasons dissenting with the majority opinion primarily based on the lack of evidence providing any compelling reason for a Hybrid Order...I see no reason for a Hybrid Order and would respectfully submit that a secure order is a more appropriate Disposition for BK at this time. In the event BK experiences a longer period of stability, then as we have seen to date, the hospital can always request an early hearing.

In Re BLA the dissenting opinion states:

In the opinion of the majority of the Board, BLA should be detained at CAMH under a hybrid medium/minimum order. I am not in agreement with this opinion...nor do I believe it is appropriate for the Board to abrogate its responsibilities to determine the

level of security to the discretion of the hospital based on the evidence before us. He has required close supervision of medication and despite this has proven to be non-compliant. Ultimately, these three cases exemplify a concern from certain members of the Board with the ability and utility of having the attending hospital be in charge of determining the security level of the accused.

In contrast to these opinions, Re JJ is an example of case wherein the Board has determined that the hospital should not be accorded the ability to determine particular conditions for the accused, but the dissenting opinions argue in favour of abdicating some responsibility to the hospital in determining conditions and security concerns. The dissenting opinion states:

The majority members of the panel considered that the safety interests of the public would be best served by removing the hospital and grounds indirectly supervised privilege from the accused's proposed disposition. The minority members' dissenting opinion is limited to this particular provision and they agree with the balance of the disposition of the majority as outlined in the above-noted reasons.

It is the minority members' view that the hospital should be extended the confidence of appropriately monitoring and measuring JJ's behaviour and compliance in the coming year and that any indirectly supervised hospital and grounds access would only be provided after careful consideration of the risk involved and done in a step-wise fashion.

Finally, in Re DD in a rare instance of the Board responding directly the issue of dissent, the majority argue against a hybrid order stating:

The majority concluded, given the fact that DD is presently residing on a minimum secure unit, that it could not issue a Disposition directing that DD be detained on a medium secure unit with any form of ability to transfer permanently or temporarily DD to

the minimum unit. The majority feel that it is the obligation of the Review Board to direct the appropriate level of security and that it was simply not open to the Board to grant the Disposition as suggested by the one member of the Board.

In this case, the minority member who is identified as a sitting judge and legal member of the Board has argued in favour of a hybrid order. The accused, currently residing on a minimum secure unit, has fluctuated between security levels over time, and the hospital representatives have asked for a hybrid order provisioning residence on a medium secure unit, with the discretion to move the accused to a minimum secure unit, as required. The majority members of the Board state that since the accused is currently residing on the minimum security ward, it would be considered a deprivation of liberty to have the accused fluctuating between security levels without holding a new hearing and conducting a review through the Review Board hearings process. Under section 672.81 of the Criminal Code, provisions are made for the required annual review hearings for an individual found NCRMD, as well as additional mandatory reviews in a case where “where the person in charge of the accused has increased the restrictions on the liberty of the accused significantly for a period exceeding seven days”. The dissenting member, however, argues that the proposed disposition “would award the hospital an overarching authority to detain the accused in a medium secure unit. The ability of the hospital to temporarily transfer the patient to a minimum secure unit does not confer any particular liberties on the accused and therefore moving the accused back to medium after a stay in minimum secure unit would not constitute a restriction of liberty”.

The ambiguity played out in the dissenting opinions highlights a complexity and uncertainty with the mandate, roles and responsibilities of the Board in light of the competing priorities of the hospital, forensic psychiatry generally, and the accused’s liberty interests. On

one hand, the Board must be seen to accommodate, in accordance with fundamental justice, the rights to liberty and security of the person, as defined in the Canadian Charter of Rights and Freedoms and provisioned in section 672.81 of the Criminal Code. On the other hand, the Board must balance the interests of the hospital in determining the “appropriate” treatment for the accused as determined by systemic appraisals, with the responsibility of the Board to be the arbiter determining the disposition and conditions of an accused under its purview.

These competing demands can be seen in light of the notion of secondary risk management and professional responsibility. There is, as noted, an apparent confusion of tongues over where the responsibility for the directed treatment, intervention and management of the accused originates. At the outset, the Board is given the discretion to determine the initial disposition of the accused, in terms of an absolute discharge, condition discharge, or detention order, and secondarily any conditions to be assigned to the latter two dispositions. At this point, an attending hospital, psychiatrist, and treatment team are given day to day management and control duties as well as become the so-called experts on the accused responsible with reporting the development in their condition to the Board at hearings. This rupture in responsibility over control and management duties of an individual can lead to systemic concerns over the possibility of failures of prediction and decision, and can result in so-called defensive decision-making. Power (2004) describes defensive decision-making as an orientation around risk. A defensive preoccupation with reputational and legal risks can come to dominate the operations of a particular system. In this case, the Board can be seen to employ resistance to particular articulations of authority and responsibility in order to reduce the possible socio-political blowback. Thus records are maintained in a particular form and decisions are constructed in such a way as to satisfy the possibility of legal consumption as well as for internal defensive

purposes. The institutional black-boxing found in the justifications of the Board, as described previously, can be understood as a defensive orientation around the complexity of legal and mental health decision-making that conflate the liberty interests of an individual and the safety interests of the public. In constructing decisions that are fairly homogenous, apparently objective and largely devoid of overt opinion, the Board is seen to delimit its breadth as part of routine risk management. Power (2004) offers an illustration of a defensive orientation similar to what has been described in the justification process of the Board. The author writes (2004, p. 46):

“Assume that, a bit like auditors, I have a statutory duty to give employment references for my students. As the perceived risks of litigation resulting from the giving of such references goes up, the content will tend to be restricted to factual data capable of clear verification; no opinion will be offered. As this practice takes hold, the value of references for information purposes will go down and will be sought for formal reasons (to defend a decision to employ taken on other grounds) or not sought at all. In both cases, the risk to the writer of the reference may actually go down because of the way it has been devalued. As a result, society will have more of what it does not really need – certifications and non-opinions which are commonly accepted as useless and which are time-consuming and distracting to produce – and less of what it does – valuable but vulnerable judgements based on the best available knowledge to inform decisions in the face of uncertainty.

This is the essential pathology of a systemic orientation around risk management. In terms of the Board’s production of justifications for disposition decisions, their attendant value in terms of understanding process and the assessment of an NCRMD accused is directly related to the transparency through which those justifications are based.

This is exemplified in the continued struggle to determine the appropriateness of abrogating responsibility and confidence to other institutional parties with the management of an accused – either due to legal concerns, or due to safety concerns. Ultimately, this is done to the detriment of the accused, whose liberty interests are not necessarily valued intrinsically, but towards a means to an end in debating responsibility for the supposed care and ultimate control of those liberty interests by some vested authority concerned with issues of political favour, reputation and continued socio-political authority.

Defensive decision-making thus places the vested interests of the institutions given the authority to manage individuals deemed a risk to the larger public ethos above the individual liberty interests of the individual. Indeed this is legislated in the provisions of the Board to ensure the safety of the public first, followed by the interests of the accused. The concept of *moral hazard* in economics refers to when one party takes more risks because another party bears the costs of those risks. This can occur similarly in problems of principals and agents, wherein the agent, hired by the principle to perform a service, operates in their own interests based on asymmetrical (different or additional) information to the detriment of the principle who is unable to adequately monitor the performance of the agent. The issue of a more literal moral hazard can be seen to occur when risk management principles are applied by governing agents, in this case legal actors, forensic psychiatrists, and hospital staff, with a primacy over the interests of the principles, in this case the NCRMD individual, under the care and control of those governing agents. Due to the liberty interests involved and the normative standards guiding the justifications of the Board, the morality in this case references an ethics of behaviour that is seen to appropriate and constrain the liberty interests of the accused, rather than uphold them as claimed for example in the Re DD case outlined above.

Furthermore, it is intriguing to note that while victim impact statements and the accused are to be involved in the process, there is a total lack of the presence of these in the rationales. There is constant reference to the hospital, its reports and the attending psychiatrist, but no indication of reference to the accused. In this sense, the accused lacks involvement in the process by which their own liberty is to be determined. Indeed, Livingston et al., (2016) found in an analysis of patient experience in the NCRMD review board hearing process, that accused individuals interpret their experience at the hearing as being kept silent as defense counsel tries to “protect them from themselves”, or the accused are left to the end of the hearing, rarely having much chance to weigh in on their own disposition. Sadler (2005, p. 452) notes that in constructing normativity and a politic of behaviour, “psychiatric institutions tend to drift toward self-interest and away from patients’ interests. Stated bluntly, institutions tend to develop rules and regulations that progressively serve their own interests, more than individual interests”.

One final observation that is intriguing in its omission is the overt reliance on actuarial assessment in evaluating risk. It is possible that in accepting the evidence of the hospital and the attending psychiatrist that the Board is implicitly accepting actuarial assessments that have occurred as part of the hospital’s assessment of the individual. However, without mention of how these are interpreted, their application in the assessment process for NCRMD accused is left unclear. In only two cases were the risk assessment scores clearly implicated in the justification for decision made by the review board. In *Re CJ* the Board states:

His score on the HCR-20 was 25/40, representing a "moderate" risk. CJ was reassessed using the HCR-20 in 2011 and 2012, and his scores were 15 and 11, respectively. These are both below his initial score of 25, and both suggest a reduction in risk of reoffending.

Based on these, as well as a clinical assessment of risk, Dr. S's opinion was that CJ no longer represents a significant risk to the safety of the public.

In Re KK the Board states “The risk assessment conducted indicates that the risk is low and she is entitled to an absolute discharge on that basis.”

Importantly, these two cases indicate a professional understanding that actuarial assessment is objective and incontrovertible – that the level of risk identified is a clear representation of the true or natural predictive risk associated with the individual. Indeed, in Re CJ, the Board simply notes the regression of HCR-20 scores as though they hold an intrinsic explanatory value in terms of quantifying the nature of the accused’s risk profile. As noted previously, Gulayets (2016) reported a high correlation between expert witness recommendations and case outcomes in NCRMD verdicts in Canada and its equivalent in the United States. Given the preponderance of expert witness testimony and how closely they are linked in terms of agreement across samples, the Board should be inclined to indicate through their justification how they have interpreted the use and secondary interpretation of a risk assessment by a clinician providing expert evidence. Gatowski et al.’s (2001) study identified that judges, on the whole, lack the necessary knowledge necessitated by the *Daubert standards* to scrutinize and assess expert evidence. While the Mental Health Review Board panel is made up of a combination of legal and psychiatric members, the requirement is to have one practicing psychiatrist, and another individual trained in psychiatry or medicine. There remain three members to be sitting on a panel at a given time that do not necessarily have the same diagnostics and assessment training. Thus, as gatekeepers to the expert witness evidence proffered at a hearing, it becomes important in understanding the internal logic of the Board that it documents in its justification process an interpretation of risk assessments conducted by the

hospital and attending psychiatrists. Importantly, from data accrued during the National Trajectory Project analyzing NCRMD cases longitudinally across the review board process, only 17% of cases indicated the use of a formal risk assessment conducted based on the case files available to the review boards or through expert testimony delivered at the hearing (Crocker, Nicholls, Charette & Seto, 2014). However, factors from two common risk assessment tools, the HCR-20 and the VRAG, were found to be used often at the hearings, but these were not presented as being from a particular risk assessment tool or validated in any sense.

One would expect a level of transparency in what is being admitted as evidence and the justification for doing so, given the importance of a particular disposition decision. The ultimate disposition is important because it reflects a delicate balance between the civil liberties of the individual found NCRMD and the safety of the public, as well as sensitivity to public perceptions of procedural justice (Crocker et al., 2014). In *Winko* (1999, para. 56), the Court wrote regarding the notion of risk assessment:

This is not to suggest that the determination of whether an NCR offender poses a significant threat to the safety of the public is a simple matter. Dangerousness has been described as a ‘protean concept’...It concerns probabilities, not facts, and involves estimations based on moral, interpersonal, political and sometimes arbitrary criteria.

In a more recent case, *R. v. Owen* (2003, para. 25), the Supreme Court of Canada states that “it is of central importance to the constitutional validity of this statutory arrangement that the individual, who by definition did not at the time of the offence appreciate what he or she was doing, or that it was wrong, be confined only for reasons of public protection, not punishment”. If the review board is ultimately justifying its disposition decision on a broad range of criteria that is presumed to be scientifically validated based on its source, it creates a vacuum of potential

consideration with regard to the individual whose liberty is being determined in a given case.

The lack of clear justification for accepting a proposed risk assessment of the individual, or not, muddles the picture of decision-making rather than making it more transparent.

Conclusion

The role of administration in forensic psychiatry in a more diffused community-focused psychiatric system, across professional and lay supports, allows for different regimes of control to be enacted throughout various locales. Individual treatment and management is fluid across configurations of behaviour management and surveillance. From forensic institutions of varying security levels, to half way houses, day centers and community treatment programs like the ACT team. This is part and parcel of the larger ethos surrounding the structuration of risk as a division over hierarchical levels in the case of the review board, the notions of significant versus trivial harm, the concepts of varying levels of security of the forensic institutions and the varying levels of dispositions afforded to the judiciary in detention orders, conditional discharge orders and absolute discharge orders. It thus becomes a matter of administering a heterogeneous group of individuals, waylaid from normalized loci of control in the community towards the vector of criminal justice and forensic psychiatry, across these varying locations of management according to prescribed risk factors. Psychiatry as an institution of social control enacts an omnidirectional monitoring of behavioural risk across the community.

As risk level lowers, mental health is increasingly governed through the community and the family, away from strictly professional organizations. Rose (1998) states that “(...) through strategies that seek to enhance, intensify and instrumentalize the apparently natural bonds of obligation between members of domestic units, the self-governing family is urged, educated and obliged to take on the socio-political responsibility of managing its own mental health problems

and its own problematic members.” (p.183). As the focus of mainline psychiatry shifts from clinical factors and diagnosis to public safety and the attendant administration of those apparently risky individuals, it becomes impossible to further both the interests of the community as an arena of risk and the interests of those deemed psychiatrically risky.

In the post de-institutionalization period, psychiatry’s role in determining issues of security has changed. Previously, with the advent of the asylum, confinement to an institution was considered necessary and sufficient for treatment of individuals considered a threat to the safety of the public. Post de-institutionalization, the act of confinement becomes less if not entirely unnecessary insofar as the community, as a policy and practical locale, is determined to be able to fix the preponderance of differences from normative behaviour marked as dangerous once that dangerousness has been adequately pacified through pharmacological therapeutics and a delegation of responsibility and subsequent reputation stakes in constructing false negative dispositions. Thus, by way of increased synapses across other social institutions, an obfuscated role in the determination of detention emerges for forensic psychiatry. This may account for psychiatry’s increasing relations with the criminal justice system, in relation to notions of responsibility, expert witnesses, care and treatment of the mentally ill who are imprisoned. There is an increased salience to the role of forensic psychiatry in the process of determining and administering disposition decisions for NCRMD accused. Psychiatric institutions are defined not in terms of cure or care, but in terms of the secure containment of risk (Grounds, 1995). Confinement is a way to contain those deemed most risky to the larger social ethics of behaviour until that risk can be delegated to the community.

The judgment of risk, then, becomes a judgment not simply of diagnostic synthesis, aligned with the dominant ideology of the psychiatric profession, namely the DSM and its

attendant criteria. Rather it becomes quotidian or altogether ordinary, insofar as the classification of individuals in terms of risk to the public is done partly on medical terms, and partly on other matters such as employability, family cohesion, social connections, and the capacity to become financially independent.

Thus a key disposition criterion, while conceptually based on the mental capacity of the individual for proposed non-risky behaviour, is implicated in the more relevant issue of what should be done with the individual in terms of an administrative task for managing their particular risk portrait. Should they be discharged absolutely, discharged with conditions or detained, and should they be sent to varying restricted levels of institutions, to half way houses, to day care centers, or to pre-approved housing at the more micro level under the auspices of community agencies like the ACT team or Link team. The logic of prediction and risk, then, comes to dominate the logics of strict diagnosis and medical intervention.

This understanding of the administration of risk is in line with the legislative ideals of the *Winko* decision, where the Supreme Court encouraged review boards to investigate and consider all manner of evidence related to the case. In this way, the usual evidentiary standards are sidestepped insofar as what is deemed critical to risk from a purely expert point of view of the hospital and attending psychiatrists as well as the board will be available for invocation. The potential ramification of such evidentiary standards is an attendant lack of transparency in how the Board is conceptualizing the notion of risk and administering their wards across the community.

Lupton (1993) suggests that the obligation to assess, evaluate and minimize risk is significantly different from the obligation to care and control, or to diagnose and cure, or to befriend and reintegrate. The “psy” professional, through an interface with the review board and

judiciary, is the expert through which this practice of social ordering and control becomes legitimated, by transposing their expert system of knowledge across a more diffuse set of criteria. Thus, where prior research identifies particular factors, terms or phrases in the disposition decisions as being relevant to the conceptualization of risk, it stops short of investigating what this construction of a risk profile ultimately says about the discursive structure of those involved in the process.

Dangerousness and risk are recast as a calculation based on a combination of evidence about past conduct and professional judgments bearing upon the likelihood of failures to exercise the capacities of self-control and self-mastery over one's impulses towards others or feelings toward the self. Level of risk has become the key criterion for intervention. The established duty under a neoliberal politic of self-management and self-control provides a basis for new divisions within the subjects of psychiatry themselves. The divide is primarily between those "good subjects of psychiatry" who are medication compliant, keep appointments, are able to assess their coping performance in a way that aligns with the assessment of professionals in such a way as to demonstrate "insight" in a circumscribed way, and those "bad subjects of psychiatry". For professionals, the will to cure becomes little more than the inculcation of a particular type of relation to the self, involving prudent self-management, making treatment plans ensconced in the rationale for decision as legitimate and holistically constructed, and learning skills of management of everyday life to manage being "ill for life" through inroads into community psychiatry and self-management.

Risk, as differentially conceptualized under a new mentality of risk, operates in both medical and quotidian terms. Where contemporary risk research conceives of actuarial risk assessments and homogenous management of larger groups of populations of at risk individuals,

Rose (1998) proposes that this hybrid risk strategy, consolidating a medicalized language and the management of everyday life of individuals in order to enact a particular normative engagement in the community is more applicable to a neoliberalist frame of governance. Therefore, dangerousness and risk associated with mental disorder are reconceptualised under new mentalities of risk as relating to the ethics of so-called productive and appropriate behaviour, not simply whether or not a particular diagnosis and the particular accused is at a risk of committing violent re-offenses. Indeed, as mentioned, the general prison population sees a recidivism rate of 34% after 3 years of release into the community, while NCRMD accused see a recidivism rate of 9% over 3 years following absolute discharge, with 0.6% being a serious violent re-offense (Charette et al., 2015). It could very well be, however, that the focus on establishing community supports in order to manage the so-called quotidian risk of the individual through the community is effectively reducing recidivism rates.

NCRMD accused represent a liminal state between being “at risk”, or in need of treatment considered by others to be therapeutic to their present conditions, and “risky”, or in need for directed control to enact management of that risk to the individual and the community. The process through which individuals are rendered both controllable and medicalized “patients” of a system of law and biopsychiatry is a result of what Scheff (1999) calls the identification of “residual cases”. Residual cases are those individuals deemed to be unmanageable within pre-existing institutions like prisons, voluntary mental health services or through community services. As NCRMD accused are considered both dangerous on account of their mental disorder, but also “ill” or “sick” because of it, they require control and care – a paradoxical incongruity that metes out social ordering and institutionalization to a population unable to resist the labels ascribed to them through a system of psychopharmaceutical pacification.

The enactment of Bill C-14, promoting victim impact statements concurrently with the new high-risk designation for NCRMD accused are considered broadly as either punitive or warranted given the possible danger representative of the NCRMD population. Under this analysis, however, the recent policy changes can be seen as a direct extension of current ideology and praxis. The analysis of the content of the NCRMD rationale for decision highlights a fundamental ideology carried out through discursive turns to medicalize and thus legitimize psychiatry in order to augment the credibility of its system of knowledge. In constructing the assessment of risk around insight, compliance, wellness and the administration of the individual across the community at differing locales, it offers an occluded objective basis through which social control and ordering can be undertaken. The inclusion of victim impact statements can be seen as window dressing in the hope of appearing more holistic in its practices, as the review board process is dominated by the experts – psychiatric and legal – in attendance. Ultimately, the high-risk designation, rather than representing a punitive turn per se, is an extension of the need for continued professional accountancy and secondary risk management.

The cases under study exemplify this shift in risk mentality, in which diagnosis is secondary to administrative and management concerns related to the individual's everyday life. Diagnosis is simply a medicalizing and legitimating factor in the establishment of particular regimes of control for those coming under the purview of the criminal justice and mental health systems through NCRMD designations.

Furthermore, the concern with the administration of risk is inverted as well toward the experts and professionals in terms of secondary risk management. In this way, the liberty interests of the accused are seen as secondary, both in ideology (policy/legislation) and in practice (the Board justifications) to the primacy of the safety of the moral norms of society.

Ultimately, failure on the part of the Board in erring in a false negative case that results in recidivism trumps more careful but necessarily uncertain professional judgment. Rather than predict a dystopian future centered around the extremes of prophylactic intervention into the minutia of everyday life based on all order of static and dynamic factors, however, the politics of risk suggests, more benignly, a presumption that the logic of normalization, of managing risk, demands better information, more coordination between more professionals, and more stringent codes of conduct and tighter standards, rather than a reconfiguration of this particular system. Failure, in terms of forensic psychiatric recidivism, is a signpost for a tighter calibration of the current regime, rather than an attempt to define new understandings of conduct and the ethics of living

In light of this new conceptualization of the mentalities of risk, the analysis offers a point of departure for reconsidering the notion of insight and its use in the cases presented above. Through a decomplexified notion of insight and its conflation with various terms in the rationale for decision, an individual demonstrating “sound insight” must be observed to demonstrate: regret for their offence and circumstances; acknowledgement of their symptoms and mental condition as the product of an ascribed mental illness, that those symptoms are negative, problems of living, and must be addressed through psychotropic treatment; description of a new personal history including a trajectory of becoming ill and staying ill for life; elaboration of modest goals and hopes for a modified future; and trust in and gratitude for effective medical treatment (Hamilton & Roper, 2006). As Hamilton and Roper (2006) note as well, in analyzing the use of the terms insight, compliance and other medicalized language in mental health treatment, that the individual who demonstrates “sound insight” is a reproduction of Foucault’s “docile body”. For Foucault (1977), a docile body is an individual who is set up to take on the

transformation of the self through integrated power relations guiding and subjectifying it in light of a particular way of being and lifestyle management. In this sense, however, the individual found NCRMD is essentially half of the docile body, whereby a focus on psychotropic medication renders the individual placated, and thus manageable outside the purview of the review board.

The process of risk management is thus less a directed attempt to coerce or control as it is an inevitable discursive struggle between ideologically opposed but facile categorizations of risky and non-risky, healthy and ill, and criminal and non-criminal. The presumption by the former is that the latter will be lesser, the power struggle is bred within the constructed disambiguation of the dyads. Thus when an individual arrives at a hearing as a criminal with a known severe mental illness – severe insofar as it matches the legal definition of a mental illness capable of reducing what is to be understood as rational thought by the judiciary – he or she is placed in a particular position relative to the others involved in the tribunal. (Hamilton & Roper, 2006; Dallaire et al., 2000). The ability to declare behaviour and experience as “ill”, “problematic”, or “disordered” confers significant social power (Sadler, 2005, p.4). As Foucault notes (1982), power in a set of strategic games that is a ubiquitous feature of interactions insofar as it structures the possible fields of interest for those in the interaction. This is not necessarily negative in the sense of a directed social control; rather it is the rationality of governance, the productive power of empowering an individual to make decisions on their own to align themselves within a particular understanding of a productive individual. The ambiguity of the terms used by the board confers the significant social power over a psychiatric system to assess, manage and determine cases at a forensic level.

Conclusion

The institutionalization, control and so-called emancipation of individuals is not a particularly original sequence of events. However, the social praxis or the means by which this process occurs is an important point to consider in seeking an understanding of our larger social processes and our relationship as a whole to these networked systems of control. Rather than separate systems, they are intimately tied to the larger project of neoliberal governance that considers how choices and policy implications are made and justified based on the ground level functioning of particular expert systems of social order.

It is through such an analysis that one can begin to conceive of the verdict for those tending to conflict by virtue of their behaviour from the common convictions according to which the ethics of living are determined. Disturbances of the normative buoyancy of society occur with an expectation that they will be managed until such time as they can be repurposed according to a particular normativity. Self-agency and responsibility as they relate to a circumscribed but presupposed range of behaviour establishes the index of psychological health, and once defaulted can only ever be seen as a symptom of psychological dysfunction in the individual. The psy-disciplines, once established as empirically driven, medicalized and scientifically legitimated authorities on the purpose and direction of so-called productive behaviour leads to the approbation of particular behaviours and at once the immunization against a charge of complacency and those who denigrate its authority.

Conceptions of psychological health and wellness rooted in an enlightened positivism establish the exchange rate between productivity and safety on the one hand, and inefficiency and dangerousness on the other, thereby determining the value of behaviour. Through a discursive turn, the biopsychiatric system in concert with the legal system underlying the review

board provides accounts of how the accused understands their sense of self within a medicalized understanding of behaviour. Within a biopsychiatric understanding of illness that borrows from general medicine in establishing concrete symptoms and evidence of disorder, the system constructs and deploys discursive elements such as insight, compliance and wellness that have an objectifying effect in legitimating the assessments of the accused's potential risk profile. These discursive turns subsequently subjectify and subjugate the self-evaluations of the accused where their own understanding seems to dissent from the view of the board. In this way, disagreement on the part of the accused is considered illness, while agreement is considered as insightful wellness.

At the outset, this paper sought to contribute an interpretation of the discursive conceptualization and deployment of the terms and processes used to justify decisions made by the Ontario Mental Health Review Board in assessing risk. As noted throughout the *Results and Discussions* section, there is a particular medicalization of terms that suggests an objective, sterile evaluation of behaviour from an established expert system in the form of forensic biomedical psychiatry. At the same time, these terms are signposts for the involvement of the forensic psychiatric institution. In evaluating the terms used, however, there is a process of decomplexification that reduces terms such as insight to reflections of a constrained understanding of mental disorder, its etiology and its treatment. The attending psychiatric system that detains and observes NCRMD individuals is given near total and at once insular authority to determine the long- and short-term condition and progression of the individual. The reliance on this expert biopsychiatric system in both determining decisions (there are generally two mental health professionals on a given board) and in describing the condition of the accused undermines the usual evidentiary standards upheld in the criminal justice system. The interface of these two

institutions can be seen in the sterile presentation of evidence documented in the rationale for decisions, whereby psychiatry tenders evidence to the criminal justice system in such a way as to make it accessible despite some ambiguity in how the terms are to be applied and understood, while the criminal justice system is seen to consider a range of factors (medical, administrative, professional and lay supports) and protections. Risk in this sense becomes a consideration of both biomedical psychiatric terms as well as quotidian terms in how to ensure the individual considered risky can be managed in the community as productive or at least not negatively productive to the social ethics of behaviour.

The objectification and medicalization of the concept of risk veils particular paradoxical philosophical understandings of behaviour in negotiating the irrationality of mental illness with the rationality required to demonstrate insight and the ability to live a prosocial life. A concurrent transformation of the socio-legal construction of risk promotes the expansion of the biopsychiatric system into the community – not in a medical sense, but in a quotidian sense, ordering the everyday lives of the accused in the community as well as the ever-increasing population of individuals rendered under issues related to problems of living that are considered diagnosable mental disorders or related to disorders. Rather than a strictly actuarial assessment of risk in the contemporary sense, the so-called risk of significant harm for the accused and the review board is portrayed in the context of a neoliberalist conception of productive behaviour, termed here as a “social ethics of behaviour”. A social ethics of behaviour encompasses the expansion of risk thinking from a physical harm model, predicated on circumscribed risk factors, to more diffuse, quotidian, and transcendental factors across the community scape. Simply put, where an individual is seen to dissent from the common understanding of what it means to be a

responsible, productive citizen, they are considered disordered or delinquent and in need of reconfiguration or isolation.

Some authors critical of the medicalization and objectification of behaviour argue that individuals under the purview of biopsychiatry, and the psy-disciplines generally, can counter particular entailments regarding their conception of the self (Speed, 2006). Importantly, in conceptualizing power relations, Foucault (1982) emphasized the importance of the productive nature of knowledge and power, implying that power relations can be reconfigured and countered by those seeming to be subjugated by it. For example, in psychiatric consumer and survivor literature, people readily acknowledge the manipulations required in playing particular “truth games” in order to advance their own interests.

In terms of more concrete considerations, legal and clinical policies that promote a person-centered approach, valuing their contributions and understandings of behaviour, might be able to counter-balance the goal of a reduction in the risk of recidivism with individuals who are comfortable with the services and care they receive through legal and clinical institutions. Hamilton and Roper (2006, p. 421) argue that “insight, like all ‘knowledge’ that has a voice or is assumed in society, is constructed through social processes, particularly through the exercise of power”. Therefore, power exchanges determine what is relevant for consideration and legitimacy, and what counts as scientific versus lay understanding, and what is objective and rational, and what is subjective and questionable. Ultimately, Hamilton and Roper (2006) argue that through a critique of taken for granted biomedical regimes of truth, a realignment of the discursive primacy afforded such a system can occur, unseating the privileging of clinical understandings of patient behaviour and experience. By critically examining concepts understood as intrinsic and infallible, it becomes possible to identify the contingencies by which

these are reproduced. Hamilton and Roper (2006, p. 421) favour an idea that insights “are glimpses beneath the surface that be shared with curious others. We also consider insight to be a quality of perception that mental health professionals can cultivate, to more deeply understand their work, culture and the self”. In this way, insight, rather than a strictly biomedical or biopsychiatric term, is used as a medium by which clinicians and patients or consumers can interact that is less structured by a particular relationship of power – the clinician/expert and the individual/mentally ill.

Furthermore, recent changes to the legislation surrounding NCRMD hearings increased the visibility and role of the victim, and those related to the victim, in the hearing process, encouraging the use of victim impact statements. In a similar vein, it would be essential in the near term to enact policy that includes the accused and their personal accounts in the process. In respecting the rights of the accused, this would also entail a development of the administrative capabilities of the review board system. Sadler (2005) suggests that administrative capabilities can be person-centered, in the sense that monitoring and documentation procedures are conducted with the interest of the accused first and foremost. In this way, the requirement to develop reasons for decisions could be developed to encourage review boards to make more detailed, subjective and open interpretations of the hearing process, outlining all of the factors they are using in making their decisions and thus opening it up to greater scrutiny. Through black-boxing, the current regime tends toward a reduction and occlusion of the complexity of the evaluations going into risk assessments in the hearing process. By unpacking these reasons, the judiciary will similarly be able to justify their pronouncements and decisions, but would offer a more nuanced look into the decision-making process, ultimately placing the accused at a higher

position insofar as they will understand the nature and quality of the decision-making process from a strictly administrative and legal standpoint.

The problem with such a recommendation is that by definition individuals found NCRMD are impaired at the perceptual, cognitive and/or volitional level. Thus, how would one promote the consideration of a patient-perspective in the decision-making process, if it is unclear that they are in fact capable, at a base level, of considering their own best interests?

A Way Forward...

Importantly, in reconceptualizing space for a patient-centered approach and incorporating disagreement, there must be a reconfiguration of what “the best interests” of each party are, and how these relate to each other. For example, while non-violent, but so-called deviant, behaviour may be considered unnerving, it is not in and of itself a necessary condition for increased surveillance and monitoring of an individual. By critically examining the alignment of mental disorder or mental illness with socio-normative standards, it could become possible to reconceptualize the experience of mental illness, as well as the capacities of the mentally ill. As discussed, the British Psychological Society, among others, are critical of the DSM framework that focuses on a biomedical model of understanding mental disorder despite the fact that there are no clear biological markers indicative of mental illness that can consistently be used to determine a given condition. Ultimately, a model that values individual experience, thoughts and expressions, rather than strictly problematized behaviours categorized as symptoms of an apparently naturally occurring disease of the mind, can drastically reorient how psy-professionals relate to the individuals under their care. The issue with biomedical conceptualizations of mental disorders is they treat them as physiological defects that can be seen to entail the entire individual. Thus there is a conception that those suffering from severe mental disorders are

impaired globally, rather than partially, at a volitional and cognitive level. If we unseat the taken for granted approach to diagnostics, a similar reorientation away from a politics of risk toward one of uncertainty creates new and important possibilities in considering the social ethics of behaviour. Power (2004) once again describes a reformulation of risk-based regulation and a politics of risk toward a politics of uncertainty. A politics of uncertainty, much like Rorty's (1992) pragmatic anti-foundationalism, reconfigures dominant conceptions of how society and its members function and thus overcomes the institutional need to fit recalcitrant phenomena into well tried, linear frameworks of understanding (Power, 2004, p. 50-51). A politics of uncertainty must also develop the discursive capacity to challenge the ways in which current risk thinking configures risk as quantifiable and perfectly manageable. Rather, risk management under a politics of uncertainty would encourage learning and experimenting to see what works and what does not, rather than stringent expectations of the total, inalienable reduction of all risk. Power (2004, p. 61) states that this new discursive turn would "depend essentially on human capacities to imagine alternative futures to the present, rather than quantitative ambitions to predict the future." Indeed, Sadler (2005) notes that attempts to correct discordance in politics and science is naïve; we must instead respect and value discord as a way forward in formulating new ways of thinking about taken for granted assumptions about the nature of human behaviour and normativity.

The usual realm of applicability of the rationale for decision in hearings is as an administrative task, mandated of the review boards, apparently as a measure in transparency. These justifications are presented as officiated documentation of the review board decision-making process, yet in terms of detailed justification, when viewed at distance scales more attuned to the individual nature of a case, they present as summaries glossing over the intricacies

and complexities of the cases. This was described earlier as a systemic black-box, obfuscating the transference and internal processing of evidentiary and case-specific input into an apparently objective rationale for decision in justifying a particular disposition order.

While a decision made is presented as a majority decision with a zero-sum, the structure of the rationale for decision conceals many potential undulations or discrepancies in the values used to arrive at that zero-sum. It is in this sense that a politics of uncertainty can be applied to risk thinking, in the sense that while risk when quantified and defined can be understood as predictable, it is by nature unknown on individual scales. The complexity of behaviour and management cannot be jury-rigged into a reductionist normativity, thus accepting uncertainty in conceptualizing risk and behaviour is useful in opening the closure of risk thinking.

Richard Rorty's pragmatic, legal anti-foundationalism seeks social progress in the realization of the contingencies of social practices and constituted realities through particular discourses (Rorty, 1992). In this way, Rorty rejects the politicized human progress that is fundamental to Modernity, as well as the empirical, objective search for truth of the Enlightenment project. Rorty outright refuses the notions of a foundational, Universalist truth, that lies somehow outside of our social practices, but to the extent that he seeks social progress, he might be seen as at least sceptical of the Enlightenment project. For Nagel, to abandon objectivity is to simply cease knowledge acquisition, yet Rorty disagrees, suggesting "antirepresentationalists...think that the history of philosophy shows [its efforts] to have been fruitless and undesirable" (Weaver, 1992: 731). Thus, Rorty is cognizant of the potential dangerousness of a strictly Modernist, representational ethos. Insofar as Rorty rejects representationalism and universals, he conceives of a world made up of particularities. Thus, for Rorty, one can only conceive of localized knowledge and the macrostructural, unconditional

attempts by Modernist enterprises cannot possibly fulfill our needs. Indeed, Weaver states Rorty's positioning with regard to Modernity and Enlightenment by saying "if one wanted to play the game of objectivity, convergence, and privileged discourse, it would be better to pick someone more easily disposed to play that game by its own rules – not Rorty, who wants to drop the game altogether" (1992: 756).

For Rorty, there is no universal truth or "real" way of being that someone can lay claim to, rather, judging a practice or belief can only be done "by comparison...by offering alternatives to the way we presently do things" (Weaver, 1992: 757). While Rorty suggests that our entire realities are a product of contingencies, it just so happens that we developed certain vocabularies and social practices but these are scarcely the only ones available, as we are simultaneously constituted by these current practices such that we have a certain ethnocentrism in how we conceive of the world (Huang, 1994: 505). Rorty suggests that once we realize that we cannot completely rid ourselves of old practices, it will illuminate "more clearly...how we can gradually substitute some new beliefs for the old ones" (Huang, 1994: 505). Therefore, we can chip away at the seemingly immutable foundation of Modern-Enlightenment thought by offering alternative practices. Ultimately, for Rorty, the only method for continued social progress is "courageous and imaginative experimentation" (Baker, 1992: 699).

Rorty's legal pragmatism similarly regards the contingencies of the social world, arguing that indeed everything is constructed, such that representationalism cannot exist: there are no universals, or "truths" that can be appealed to. Rather, discourse can be considered useful so long as it is deemed so by a given culture, community, group or society. Rorty's major contribution is simply to suggest that our current system is not the best system, or the only way of orienting

social praxis. Rather, alternatives can and should be experimented with in order to accommodate a pluralistic society.

This way forward simply unseats the taken-for-granted approach to clinical evaluations of risk and conduct, privileging the voice of the subject over or equal to that of the subjectifier. In Foucault's *Madness and Civilization* (1988b) he states "the constitution of madness as a mental illness... thrusts into oblivion all those stammered, imperfect words without fixed syntax in which the exchange between madness and reason was made. The language of psychiatry, which is a monologue of reason about madness, has been established only on the basis of that silence." (p. x) In this excerpt, Foucault succinctly arrives at the crux of the issue, in that through discursive turns, the views and attitudes of the accused, those most affected by mental health legislation and diagnosis, the disordered themselves, come to have the smallest arena for involvement in the label and institutionalization of the construct that so vastly orders their lives.

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