Mental Health Problems in Parole Decisions:

The re-conceptualization of mental health problems as risk factors.

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ABSTRACT

Deinstitutionalization has had an impact increasing the number of offenders with mental health problems within the correctional system. Furthermore, preliminary research claims that offenders with mental health problems are disproportionately denied when applying for parole. The reasons for this are not well understood. This exploratory qualitative research draws on 48 decisions from the Parole Board of Canada decision registry, four interviews with former parole board members, and observation data from 17 parole hearings to explore how mental health problems are constructed within the conditional release decision-making process. Against a risk logic back drop, this institutional ethnography analyzes the way parole board members understand and operationalize mental health within the decision-making process. Self-regulation, medication compliance, and the role of the expert were strong themes that emerged through a content analysis. By integrating symbolic interactionism and a governmentality framework, the current study explores how mental health in parole decision-making is influenced by individual, organizational, and macro-level risk rationalities that draw on neoliberal responsibilization strategies and psy expertise. The findings are presented within Hawkin's (2002) legal decision-making framework. Policy and human rights implications are discussed.

Key words: Mental health; DSM-5; conditional release, parole, detention, risk, the expert, medication compliance; corrections; symbolic interactionism; governmentality; decision-making theory.

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To our daughters Alexis and Blayke, this dissertation is dedicated to you Stewart girls. If there was an example to be made of this process, remember how important it is to finish what you start. Perseverance! I love you both, my little monkeys xo.

To Dan, it may be incredible for you to read this, but I really have *no words* to explain the magnitude of gratitude and love I have for you. Therefore, for my purposes here I will borrow a few of the words you used wisely over the years:

And all the time she kept saying,

"I think I can, I think I can, I think I can…"

Up, up, up. The little engine climbed and climbed.

At last she reached the top of the mountain.

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LIST OF ACRONYMS

CCRA	Corrections and Conditional Release Act
CSC	Correctional Service of Canada
ETA	Escorted Temporary Absence
DP	Day Parole
FP	Full Parole
NPB	National Parole of Canada
OCI	Office of the Correctional Investigator
PBC	Parole Board of Canada
SR	Statutory Release
UTA	Unescorted Temporary Absence

Chapter 1. Introduction

It is claimed that people with mental health problems[1] spend longer periods of time in prison (Ditton 1999; Porporino and Motiuk 1995), and have higher rates of disciplinary infractions while incarcerated (Adams 1986; Ditton 1999; Gonçalves, Gonçalves, Martins, and Dirkzwager 2014; Houser and Welsh 2014; Toch, Adams, and Grant 1989). Further, it is suggested that they tend to fare worse in risk assessments than people without mental health problems (Carroll, Weiner, Coates, Galegher, and Albrio 1982; Hannah-Moffat 2004; Fitzgibbon 2007). Moreover, offenders on parole with mental health problems are returned to prison at a higher rate than offenders without mental health problems for parole condition violations as opposed to re-offending (Porporino and Motiuk 1995).

A small body of research has also studied parole release decisions and found similar discrepancies between people with and without mental health problems (Porporino and Motiuk 1995; Feder 1994; Hannah-Moffat 2004; Ditton 1999; Fitzgibbons 2007, 2008). This discrepancy is often referred to in the literature as "differential treatment" (Feder 1994, 408), inferring that mental health problems negatively influence parole decisions, reducing the likelihood of offenders with

[1] Throughout the dissertation I will draw on notions of mental health and engage with the nuanced differences between mental health and mental illness. For me, mental health is understood to exist in the absence or presence of mental illness so as to not unduly limit the parameters related to our understanding of the concept. With respect to the construction of "mental health problems", I use this term to denote that an individual's mental health is or has been constructed as a "problem" by either the institution and/or parole board members. My objective is to examine how the social and cultural conceptions of mental health, as it is understood in the offender population, influences both the people who use the construct but also those who are labelled as having mental health problems (Horwitz 2012). Therefore, for this research mental health problems are referenced in relation to the labelling of the problems related to mental health, unless I am quoting directly research that utilizes terminology or diagnostic criteria such as mental disorder or mental illness, in which I refer directly to the technical terms used by the rational – objectivist perspective.

mental health problems being released into the community. Yet, it is surprising how few studies have examined this phenomenon, especially given the strong claims that are being made. Additionally, numerous studies support the notion that mental disorders are not major risk factors for further recidivism (Wormith and Girard 2004; Porporino and Motiuk 1995; Bonta, Law, and Hanson 1998; Gendreau, Little, and Goggin 1996; Quinsey, Harris, Rice, and Cormier 1998). Recent research has challenged the differential treatment claim, finding that it is not mental health problems that directly affect parole decisions, but rather that mental health problems have an indirect effect on decisions through other factors considered in the parole release process. For example, Matejkowski, Caplan, and Cullen (2010) found that having a mental illness is associated with higher numbers of disciplinary incidents, which in turn, negatively influences parole decision-making.

With the exception of Hannah-Moffat's (2004) study, the few studies that have investigated mental health and parole decisions have done so through quantitative analysis. This method examines the relationship between mental health and parole release decisions through statistical analysis. For example, Feder (1994) investigated how psychiatric hospitalization affected the likelihood of being granted parole and found that, after she controlled for other extralegal factors, incidents of psychiatric hospitalization during incarceration had the largest impact on parole release. Feder found that offenders who did not require hospitalization were 30 times more likely to be paroled (1994, 404). Similarly, Porporino and Motiuk's (1995) study looked at outcome statistics and purported that there is a differential effect on parole decisions, based on statistically significant differences between offenders with mental health problems and offenders without mental health problems. Based on their outcome data, these authors argue that offenders with mental health problems serve longer proportions of their sentence imprisoned, are more likely to spend their time within prison at a higher security level, and are less likely to be granted various forms of conditional release. Of note, these authors also found that offenders with mental health problems are more

likely to have their conditional release revoked for technicalities than offenders without "major mental disorders" who commit new offences while on conditional release. However, as aptly noted by Porporino and Motiuk (1995) and Feder (1994), this effect could also be explained by other covariates such as a lack of programming or services in the community to offer supervisory or support services to the offender on parole. Without such supports, parole board members may be reluctant to release offenders with mental health problems to the community.

This type of analysis, using narrowly defined statistical models predicting binary single outcomes, can be particularly misleading if it detaches decision-making from the context in which it was rendered; measuring outcome-based decisions through an empirical lens that postulates a link between input and output data. Arguably, there are various and often-competing factors beyond those found at the institutional level that influence a parole board member's decision when considering parole release (Cohen 1985; Garland 2001; McCleary 1992; Feeley and Simon 1992). Hawkins' work in particular highlights the dynamic and shifting ideological, symbolic, socio-political, economic, and organizational constraints placed on decision makers who work within the complex criminal justice field. He argues that quantitative studies examining these types of decisions tend to isolate decisions as if they were not made as part of a lengthy decision-making process in which numerous players, policies, and procedures had a hand in creating the framing of how the case is presented (Hawkins 1986, 1187-1188).

I argue that a further examination into these factors can provide not only a viable explanation as to the context in which parole decisions are made, but also provide insight as to how specific factors, such as mental health, become factors subject to assessment for criminal justice professionals. When these larger socio-organizational factors are considered, it is possible that the presence of mental health problems may not influence parole release decisions to the extent to which it has been stated.

Research on parole decisions is difficult. A parole decision is the final outcome of a lengthy, multi-staged process that begins with the index offence and is shaped according to various factors such as the length of the sentence, the institution within which the offender is incarcerated, how much information is known about the offender, his/her criminal record, the relationship with his/her parole officer, opportunities within the sentence to complete programs, as well as how the individual case is articulated through their risk factors. Research that is outcome based relies upon a few assumptions. First, it assumes that one can isolate any one of the many factors in the decision-making process and attribute to that factor some degree of prediction related to the outcome. Second, attributing prediction to any one or any set of the various factors risks neglecting influence of other factors, namely the context from which the decision was rendered.

My study focuses on the decision-making process rather than the outcome and zeros in on the process by which a board member accesses, understands and makes use of the concept of mental health in their decisions. Research into parole decisions must consider the larger conceptual framework within which parole board members operate, including the risk literature as described in Chapter Five. Parole board members are trained and instructed to make decisions based on a structured framework anchored in actuarial risk assessments (Serin 2011). Risk in this context refers to an offender's perceived likelihood of re-offending and is operationalized based on various factors (such as past criminal activity) depending on the actuarial tool that is used to assess risk. The aim of this study is to deconstruct parole decisions to get at the meaning attributed to mental health in parole decisions. The influence of risk as a larger conceptual framework is understood as a critical factor of this analysis.

1.1. RESEARCH QUESTIONS

This study seeks to broaden our understanding of mental health in parole decisions and explore the ways in which and the extent to which parole board members consider mental health-related factors (e.g. self-harming and/or suicide attempt incidents, compliance with treatment or medication to treat mental health problems, and/or a formal diagnosis such as those determined by the Diagnostic and Statistical Manual (DSM) when assessing offenders for release. The following are the questions this study seeks to answer:

1. What sources and information do parole board members draw upon to ascertain the presence and/or extent of mental health issues? For example, do parole board members draw only upon a formal diagnosis as a salient factor for assessment or do they also draw upon, and if so in what ways and to what extent, other contextual data such as compliance with treatment and/or medication issues?
2. How do parole board members operationalize mental health in parole board decisions of male offenders? How is information about mental health referenced as problems and used in the record of decision-making?
3. How is mental health framed by the Parole Board of Canada (PBC) in its policies and procedures?
4. How does an indication of mental health or associated factors inform the discussion on release for male offenders?

The study will explore what information parole board members draw upon when they are referring to mental health in order to ascertain the role of diagnostic information or information on ascribed mental health behaviours in parole decisions of male offenders. By deconstructing the use of the

concept of mental health this study aims to identify assumptions present in the analysis or discourse of parole board members.

1.2. THE DSM-5 AND FORENSIC POPULATIONS

The American Psychiatric Association (APA) has identified concerns with regard to the (mis)application of the DSM-5 with regard to forensic populations and the risks associated with the use of the tool in the legal context. According to the organization, the DSM-5 was created as a diagnostic tool "to meet the needs of clinical, public health professional, and research investigators rather than the technical needs of the courts and legal professionals" (2013, 25). The organization goes on to note the risks associated with diagnostic labels if used out of the intended context. For instance, in the determination of "not criminally responsible" the courts draw on mental health experts and mental health designations in order to ascertain if the accused had the capacity to appreciate their criminal actions. Within this specific legal context, the consequences of establishing a mental disorder may have ramifications as to whether or not the criminal behaviour will be addressed within the mental health system or the criminal justice system. While the organization notes that the DSM-5 is instrumental in determining diagnostic information for this determination of responsibility, additional information is required beyond the DSM-5 related to an individual's cognitive function (APA 2013, 25).

By virtue of being convicted of a criminal offence and serving time in a federal penitentiary, the men in this study have met the legal threshold for appreciating or understanding that their actions were wrong (regardless of whether they have been diagnosed with a mental disorder). Therefore, when I reference the forensic population in this context, I am referring to a population who is serving their time in criminal justice setting, specifically federal corrections. Within this process, I explore how legal actors, in this case parole board members, draw upon the DSM-5 as a

diagnostic label within the parole decision-making context and explore how this information is used in the decision-making process. Although this research is informed by a constructivist standpoint, the concepts imposed by law, regulation and procedures regarding mental health are operationalised and implemented, not to the social construction of those concepts themselves but from a rational-objectivist standpoint.

Organization of the Study

Chapters Two through Five set the stage for me to build on my research. Chapter Two is a discussion about conditional release in Canada. In this chapter, I go over the historical context of parole and examine the organizational structure of the Parole Board of Canada and its link to the Correctional Service of Canada. I then move to discuss various political influences and reforms to conditional release, and trace how these influences conceptualize mental health problems within the offender population as a problem within the penal context. I describe how early reforms have materialized in modern form within Canadian federal corrections. Chapter Three discusses various decision- making models, paying close attention to how parole decisions have been examined in previous research studies. I suggest opportunities for further consideration to advance our understanding of parole decision-making. Chapter Four describes the impact of deinstitutionalization on the criminal justice system, a process that has been said to lead to the increased criminalization of vulnerable populations of mentally ill persons. This chapter contextualizes information with regard to why this study is of importance: once someone with mental health problems is criminalized, how are mental health problems conceptualized by decision-makers in relation to parole release decisions? Finally, Chapter Five examines the role of risk in modern penal form. In order to engage with correctional data, I must position myself as a researcher within the risk literature. Far from being a unified body of literature, the risk literature is a vast area

of knowledge that spans across different epistemological standpoints. I then trace the role of actuarial tools and experts in relation to mental health and risk.

These first chapters represent important, yet independent lines of research. I argue that the complexity of mental health in parole decisions requires an examination of the intersection of these independent domains of research.

In chapter Six, I switch gears to detail my methodology. I situate the study's epistemological foundation within the symbolic interactionist standpoint and review various decisions made regarding the sample and data collection. I pay specific attention to the insider/outsider standpoint. Finally, I review some hurdles with regard to collecting data and explain data coding. Chapter Seven is a large section that details my observations of the data, describing how parole decisions draw on mental disorders (as defined by the DSM-5) to construct offenders[2]. I provide a review of the manifest data, such as the number of times mental disorders were referenced and the types of mental disorders referenced. I then discuss more latent themes that were identified, for example the role of the psychological assessment and the expert in the determination of mental health problems. Here I draw upon data related to self-harming and suicidal behaviours and then move to an analysis of the link between references to mental health problems and the offender's ability to regulate these problems. This chapter concludes by engaging with conceptions of mental disorders and the effects of these social artifacts or labels on parole decisions (Horwitz 2012). I review the following mental disorders in an effort to examine how parole board members operationalize them in their decisions: gambling addictions, sexual paraphilia, substance abuse disorders, and *psychopathy*.

Chapter Eight is my theoretical contribution to the area of study. Here, I identify the key themes identified in the observations within Hawkins' (1986) conceptual decision-making

framework, which is situated within symbolic interactionism. I supplement this analysis with concepts from the governmentality literature in order to move beyond an interactionist framework to understand how people, in this case parole board members, have come to understand or give meaning to phenomenon through their interaction with others and institutional structures.

Chapter Nine, the final chapter is my conclusion. I provide my concluding, but by no means final thoughts, on the relationship between mental health and parole decisions. I point to human rights and policy implications linked to this research and suggest potential areas for further research.

Origins of the Research Question

My motivation for this research stemmed from witnessing the aftermath of the death of Ashley Smith, a young woman serving time in a Canadian penitentiary who killed herself by way of strangulation in front of correctional staff. As a researcher, I was intrigued that the public understood her propensity to self-harm and eventual suicide as indications of mental illness. Her death dominated the public sphere at the time. Subsequently, the discourses around the criminalization of the mentally ill and the punitive effects of the carceral environment on the mentally ill became the focus of the coroner's inquest that reviewed her death. I began to reflect on the tensions surrounding Ashley Smith's alleged mental health problems. Most critically, I was interested in the notion that her abnormal or maladaptive behaviours, i.e. tying a ligature around her neck, was taken as indication that she suffered from mental health problems. This occurred despite

the lack of a psychological assessment to confirm such.[3] I wondered how people came to assume that Ms. Smith was suffering from mental health problems[4].

I began this research from this standpoint. My familiarity with the federal correctional system by virtue of my current employment and past experiences working in various capacities in federal corrections was useful, yet posed unique difficulties for me. I underscore the sensitivity involved in examining a process related to how criminal justice professionals conceptualize mental health problems, when I too am an actor in the larger system. After much self-reflection on this conundrum, the positives seemed to outweigh the negatives. Actually, I would argue that it is this familiarity with the system that made me privy to the layers of influence that affect how a person is transformed by their case-management file into an "offender". Far too often I have witnessed how correctional officials rely upon the catchall or rhetoric of 'risk' to label behaviours associated with mental health. This observation runs counter to the basic tenets of the realist framework that relegates little risk value to mental disorders. This research project originated from my interest to answer these questions.

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[3] Although she was the recipient of hundreds of psychological and use of force interventions to prevent her from self-harming, there was no official diagnosis as per the DSM-5 (or DSM-IV) rendered by any expert that would have affirmed that indeed, she suffered from a mental disorder (OCI 2008)

[4] See newspaper editorial: Ashley Smith response a missed chance to right decades of wrong (Globe and Mail, Dawn Moore, December 12, 2014).

Chapter 2. Conditional Release in Canada

2.1. PAROLE

The western world adopted parole legislation predominantly in the late 19th century. In the United States, the first evidence of parole like practice was 1841 when John Augustus, a Boston shoemaker, persuaded the court to release offenders under his supervision (Gottfredson and Gottfredson 1988). Parole was later legislated in the United States in 1878 by Massachusetts. Similarly, in 1907 the "Probation of Offenders Act" in Britain transformed the previously ad hoc practice of relying upon notables and evangelical missionaries to grant parole into a statutory provision, which specifically empowered the court to make probation orders and to appoint professional probation officers.

In Canada, the concept of remission for good behaviour emerged in the late 19th century with the creation of the Penitentiary Act (1868). Later, Canada enacted the Ticket to Leave Act (1899), which, although devoid of an overriding purpose, permitted a form of "pardon" to offenders to be released from custody. The Parole Act (1959) was the first legislation to establish criteria for parole. The Parole Act created the National Parole Board, an independent parole decision-making authority and other various criteria for granting parole:

- The inmate had derived maximum benefit from imprisonment;
- The reform and rehabilitation of the inmate would be aided by the grant of parole;

- The release of the inmate on parole would not constitute an undue risk to society[5].

The Act was in effect until 1992 when the Corrections and Conditional Release Act (*CCRA*) was promulgated. The *CCRA* was heralded as the result of the lengthy process of reform within Canadian criminal justice policies that began in the late 1970s with the mounting concerns regarding rehabilitation and responses to crime (Correctional Law Review 15). It was the first piece of legislation that incorporated both the principles and corporate objectives for corrections and conditional release:

- Carry out sentences imposed by the courts through the safe and humane custody and supervision of offenders, and
- Assist the rehabilitation of offenders in their reintegration into the community as law abiding citizens through the provision of programs in penitentiaries and in the community.

One can link the Canadian *Charter* of Rights and Freedoms (1982) as an influential piece of legislation to the *CCRA*, namely in the expansion of the basic rights of the offender in the correctional system. This should not be surprising as the two large pieces of legislation were largely created within the same socio-political landscape.

There were enormous influences and tensions that were at play in the years leading up to the creation and enactment of the *CCRA*. One of the key issues was whether or not prisoners released into the community through a gradual and controlled reintegration process were more likely to be successful in their reintegration, henceforth contributing to the long-term protection of society (Waller 1974; Motiuk and Cousineau 2006; Andrews and Bonta 2010). In an effort to address this and other mounting tensions that were negatively affecting the perception and/or integrity of the

[5] http://www.npb-cnlc.gc.ca/about/part7_e.htm

system, the Department of Justice released a series of critical publications. These were intended to examine and provide feedback as to how to improve the criminal justice system; accompanying a series of targeted law and policy reforms during the 1970s and 1980s.

First, the department published the influential *The Criminal Law in Canadian Society* (1982), which served to set the larger political agenda or vision for federal correctional policy. Following this, a series of approximately 50 working projects examined federal law related to the criminal justice system. A sub-section of those projects were identified as the Correctional Law Review (CLR) a group mandated to discuss the alignment of correctional policies with other influential legislation, such as the *Charter of Rights and Freedoms*. The cumulative effect of these projects on parole was substantial. The papers, in particular those of the CLR, noted various shortcomings and identified key issues in conditional release including (but not limited to) the larger objective of conditional release, transparency and accountability with regard to how decisions about the offender are made, and in the rights of offenders in the conditional release process (i.e. procedural safeguards).

At about the same period, the Report of the Standing Senate Committee on Legal and Constitutional Affairs (1974) released a series of recommendations regarding parole in Canada. The Committee recommended that the National Parole Board (since renamed as PBC) adopt various organizational changes at the bureaucratic level, including defining the roles and responsibilities of those involved in the decision-making process. The Committee went on to identify and recommend that specific rights inherit to the offender within the parole process be recognized. This included the right for the offender to obtain information regarding parole decisions and revocations, the right to a parole hearing and as well established procedures to follow during the parole process.

One can trace the legal and political influences on parole over the last few decades. Canadian academics have written extensively on this topic, placing emphasis on the role rehabilitation plays within the Canadian correctional discourse (Doob, Webster, and Manson 2014; Jackson and Stewart 2009; Meyer and O'Malley 2005). Generally, Canadian academics agree that penal laws and/or release aims in Canada remain heavily entrenched with the rehabilitative aims articulated through these early reforms, such as those recommended by CLR Working Papers and the work of the Committee. However, as these Canadian scholars argue, the discourse of rehabilitation has been muted as the notion of rehabilitation has become compromised over time with the larger "get tough on crime" agenda that have heavily impacted how parole is understood in Canada (Moore and Hannah-Moffat 2005; Zinger 2012; Quan 2013; Doob, Webster, and Manson 2014).

2.2. PENAL REFORM: THE SIZE AND NATURE OF THE MENTAL HEALTH PROBLEM

One of the key pieces of legislation created through this reform period was the constitutional provision, *The Charter of Rights and Freedom* (1982). The *Charter* articulated basic rights and freedoms for citizens of Canada rendering other Canadian laws inoperable if found not to be consistent with those legislated by the *Charter*. The *Charter* had an immediate impact in the recognition of persons with unique needs or who were deemed disadvantaged[6].

One could see the influence of the *Charter* in the Government of Canada's, *The Criminal Law in Canadian Society* (1982). Pursuant to the Review, the working papers of the CLR articulated the principles of corrections in Canada, with a key focus on the discourse of rights. Working Paper No.9, entitled Mental Health Services for Penitentiary Inmates (February 1988), identified mental

[6] http://www.pch.gc.ca/eng/1355260548180/1355260638531

health (services) as a problem within corrections. The Working Paper explored issues related to mental health services, jurisdictional responsibilities related to mental health services, and rights claims for treatment, consent, and other issues related to the treatment of mental health problems. As noted by the CLR:

> At the risk of oversimplification, the problem for the correctional system is that increasing numbers of offenders in federal penitentiaries have serious psychiatric illnesses or are suffering from a range of serious behavioural disorders. Lack of sufficient treatment or other services for such offenders, who constitute 25% or more of the inmate population of some federal penitentiaries, gives rise to violence, stress, and crises that are damaging to the offender concerned and to other inmates. Moreover, the failure to address the basic human needs of so many inmates creates a debilitating and demoralizing work environment for staff and management. (Correctional Law Review 455)

It is within this broader legal context that prison authorities considered how to operationalize and institutionalize a response to meet the "mental health needs" of the offender population. From a policy perspective, this problem of mental illness had historically been managed by way of psychiatric institutions or asylums (Centre for Addiction and Mental Health 2013) Indirectly or perhaps as an unforeseen consequence of the deinstitutionalization movement, early reforms were tasked with addressing and framing the growing problem within the institution.

Canadian parliamentary and government reports began to acknowledge this issue in Canada and flagged the increase in the number of mentally ill offenders through other government documents (Ministry of the Solicitor General 1984). This process of redirecting persons in need of mental health services to the prison setting is referred to as the Criminalization of the Mentally Ill thesis:

> …the suggestion is made that in recent years the mentally disordered are being "criminalized". The argument is that with the closing down of large psychiatric institutions and the treatment of mentally ill persons in community-based facilities or on an out-patient basis, more and more mentally ill offenders, instead of being diverted into the health care system, are being diverted into the prisons. (Correctional Law Review 457)

Although more will be discussed regarding the deinstitutionalization process in coming chapters, I note for my purposes here that the CLR identified two pertinent issues related to the increasing numbers of offenders with mental health problems in Canadian prisons. First, the CLR articulated clearly that the government had a "constitutional responsibility" to care for and treat the mental health needs of offenders. This recommendation is anchored in early policy statements by the Canadian Royal Commission (Archambault Report) of the state's role in rehabilitation of the offender:

> The undeniable responsibility of the state to those held in its custody is to see that they are not returned to freedom worse than when they were taken in charge. This responsibility has been officially recognized in Canada for nearly a century but, although recognized, it has not been discharged. The evidence before the Commission convinced us that there are very few, if any, prisoners who enter our penitentiaries who do not leave them worse members of society than when they entered them. (Archambault,1938: 100)

Second, the CLR flagged issues of mental illness important insofar as to how it could constitute a threat to public safety. In its articulation of the over-representation of the offenders with mental health problems, the CLR was explicit that issues related to mentally ill offenders were of utmost importance when offenders were also identified as "dangerous" (Correctional Law Review 485). To this aim, the CLR recommended:

> Federal correctional legislation should state in all significant institutional decision-making processes including placement, classification, transfers, disciplinary proceedings and release decisions the mental health needs of the inmate shall be given reasonable consideration along with the security needs of the institution and the protection of society (Correctional Law Review 485).

We can locate the framing of the problem of "mental health", in particular as a public safety issue, in the early policy reform movement. This movement was firmly anchored in Canadian reintegration and rehabilitation policy aims and informed the basis of the *CCRA,* in particular to the sections of the law that speak directly to the subject of mental health in offenders. The following discussion will

trace the impact of these early influences of the *CCRA*, CLR, the Senate Report and the *Charter* on current policies that guide conditional release decision-making.

2.3. CONDITIONAL RELEASE

Conditional release is identified as the period of time that federal offenders serve in the community as an alternative to incarceration. The *CCRA* and the corresponding *CCRA* Regulations enacted in 1992 constitute the specific legislative framework for all forms of conditional release. As discussed above, the laws specify the guiding principles of conditional release as well as identify the relevant decision-making authorities with regard to conditional releases, and parole in particular. Parole is one form of conditional release; however, it is categorized into many types: day parole[7], full parole[8]; statutory release[9]; and temporary absence[10]. The type of parole for which a federal offender is eligible for is based on numerous factors including but not limited to: eligibility dates (completing minimum requirement of their sentence), risk level, progress toward correctional plan, etc. The *CCRA* grants the PBC the exclusive authority to grant, deny, revoke, and suspend parole.

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[7] "Day Parole: A form of conditional release that allows the offender to participate in community-based activities. It is granted at the discretion of the PBC for a period of up to six months to prepare the inmate for full parole or statutory release. The offender is supervised by CSC and must return nightly to a penitentiary or a halfway house." (PBC 2012-01-11)

[8] "Full Parole: A form of conditional release granted at the discretion of the PBC that allows an offender to live in the community, subject to conditions and supervised by CSC, and to demonstrate that the individual can be a law-abiding member of society." (PBC 2012-01-11)

[9] "Statutory Release: By law, most offenders who are serving determinate sentences, and who have not been granted parole nor had their parole revoked, must be released on statutory release automatically after having served two-thirds of their sentence. Statutory release does not require a decision by the PBC." (PBC 2012-01-11)

[10] Temporary absences are the first type of release that an offender may receive. Temporary absences may be escorted (ETA) or unescorted (UTA). This type of release may be authorized for various reasons, including for work in community service projects, contact with family, personal development, and medical reasons (PBC 2012-01-11).

The PBC is also responsible for decisions related to detention (i.e. ordering detention and reviewing annual detention decisions). All conditional release and detention decisions are based on a process that includes risk assessments and file reviews that are presented by the CSC[11].

The PBC is structured with five regional offices across Canada, as well as a national office in Ottawa. Board members are university educated individuals who had a previous background in a decision-making environment. Potential candidates compete in a competitive process. Successful candidates are appointed by the Government of Canada and work for the PBC as independent decision-makers who are responsible for independently reviewing all documentation related to a federal offender's file and assessing the offender's risk to reoffend. The parole board members make all decisions of parole and/or revoke suspensions.

The *CCRA* requires that the PBC adopt policies to inform and guide parole decisions. These policies provide the policy framework and guide decision-making by Board Members. Accordingly, all policies must flow from their primary assumption:

> 1) protection of society is the paramount consideration in any conditional release decision,
>
> 2) supervised release increases the offender's potential for successful reintegration and, thereby, contributes to the long-term protection of society, and
>
> 3) restrictions on the freedom of the offender in the community must be limited to those necessary and reasonable to protect society and to facilitate reintegration (PBC *Decision-Making Policy Manual* S.1.2).

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[11] PBC also is responsible for record suspension decision. A record suspension allows people who were convicted of a criminal offence, but have completed their sentence and demonstrated they are law-abiding citizens, to have their criminal record kept separate and apart from other criminal records. Under the Criminal Records Act (CRA), the Parole Board of Canada (PBC) may grant, deny, or revoke record suspensions for convictions under federal acts or regulations of Canada (PBC 2013-02-10).

Parole release decisions in Canada represent the culmination of a process within an offender's sentence in which he or she is assessed on a wide variety of pre-established and structured factors (referred to as criminogenic factors in Canada), in order to inform an assessment of risk. This assessment includes: a review of relevant and case specific actuarial measures of the risk to re-offend; criminal, social and conditional release history; factors affecting social control; responsiveness to programming and interventions; institutional and community behaviour, offender change and, release plan or community management strategies (*PBC 2.1 8*) The assessment process is required by policy to be a structured approach, in which decisions are made in accordance with both actuarial, clinical, and social factors by the decision maker.

One can see the use of experts from the psychology disciplines on the parole process. Section 2.5 of the PBC *Decision-Making Policy Manual* directs that assessments by psychologists/psychiatrists be used as key information regarding the offender's mental health and/or risk level. Moreover, the policy directs that the PBC retain a form of a psychological/psychiatric assessment[12] for the decision-making process for specific violent or sexual offences.

[12] The PBC differentiates between a Psychiatric and a Psychological Risk Assessment in their manual. According to the PBC Manual (2014), a Psychiatric Assessment is an assessment which addresses mental illness or disorder and the mental capacity of the offender whereas a Psychological Risk Assessment is an evaluation of offender risk, needs, responsivity and the manageability of risk, done from a psycho-social perspective, utilizing a variety of scientifically-validated assessment methodologies in an integrated process. A risk assessment would also include reference to appropriate strategies for the management of risk.

5. A psychological risk assessment is required for a review involving:

a. persistent violence, as demonstrated by three or more Schedule I offences, which occurred on different days, where each conviction led to a sentence of at least six months duration;

b. gratuitous violence, as demonstrated by excessive violence beyond that which is "required" to meet an end, or evidence of sadistic behavior or torture;

c. a detention referral;

d. conditional release for an offender with an indeterminate or life sentence; and

e. a high risk sex offender. This may be in the form of a specialized sex offender assessment. (PBC 2015)

Likewise, Correctional Service of Canada's *Pre-Release Decision-making* policy, which is outlined in Commissioner's Directive 712-1, governs the process for CSC to ensure that an assessment and subsequent documents for the purpose of pre-release decisions for conditional release are completed for review by the PBC. For example, according to CD 712-1 S.34, there is a mandatory requirement for a psychological risk assessment for a sub population of offenders who are applying for conditional release:

Mandatory Referral Criteria for Inmates

34. A psychological risk assessment is mandatory (if one has not already been completed) for inmates who meet any of the following criteria:

a. persistent violence

b. gratuitous violence

c. referrals for detention

d. conditional release reviews for inmates with indeterminate or life sentences, or

e. sex offenders identified in the Specialized Sex Offender Assessment as:

i. high risk offenders, or

ii. moderate risk offenders who remain untreated or have dropped out of the program

2.4. PAROLE HEARINGS

A secondary part of the parole release process that may contribute to the decision-making process is the parole hearing, an interview style meeting between the offender applying for parole and the Parole Board of Canada members. The *CCRA* 140 1 (a-e) outlines the cases where the PBC shall review a case by way of a hearing unless waived by the offender:

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140. (1) The Board shall conduct the review of the case of an offender by way of a hearing, conducted in whichever of the two official languages of Canada is requested by the offender, unless the offender waives the right to a hearing in writing or refuses to attend the hearing, in the following classes of cases:

(a) the first review for day parole pursuant to subsection 122(1), except in respect of an offender serving a sentence of less than two years;

(b) the first review for full parole under subsection 123(1) and subsequent reviews under subsection 123(5) or (5.1);

(c) a review conducted pursuant to section 129 or subsection 130(1) or 131(1);

(d) a review following a cancellation of parole; and

(e) any review of a class specified in the regulations.

The *CCRA* also provides the PBC with the power to review any case not referred.

The hearing may include observers of the public. Observers must register with the PBC prior to the date of the hearing and are permitted to observe the process; however, no observer is permitted to sit during the deliberations of the board or to participate in the hearing itself. All hearings are audio-recorded and all procedural safeguards are reviewed during the hearings. For example, the offender must state their name and verify whether or not they received a copy of all assessments that the PBC reviewed in preparation of the hearing. In the case of aboriginal offenders,

the hearing may be conducted by way of a circle hearing, which allows for the traditional and spiritual influences when the hearing is conducted[13].

Finally, an assistant may represent the offender. An assistant is an individual who is able to represent the offender to the board. During the hearing, the offender may consult with an assistant; yet even with an assistant the offender remains responsible for responding directly to all questions asked of him or her during the hearing.

2.5. PAROLE DECISION REGISTRY

Each parole decision contains an assessment documenting the parole board member's reason for their decision. According to the PBC's *Decision-Making Policy Manual*, this structured decision sheet will take into consideration the following points:

[13] A circle hearing is an elder assisted process whereby the board uses an alternative process that is considered by the PBC to be responsive to the cultural and traditional needs of the Aboriginal community. My sample did not include a circle hearing.

a. the type of decision and summary of the legal criteria for the review;
b. an overview of the offender's sentence and an analysis of the offender's criminal, social and conditional release history;
c. a summary of the actuarial measures of the risk to re-offend, where applicable;
d. analytical statements of all relevant aspects of the case, including aggravating and mitigating factors related to the risk to re-offend and discordant information of importance;
e. the extent to which the offender has addressed those risk related needs and whether or not there has been indication of change in the offender which would increase their potential for successful re-integration;
f. an analysis of the release plan and community supervision strategies to manage the offender's risk;
g. an overview of the offender's representations obtained in writing or, if applicable, at the hearing;
h. a concluding assessment of whether or not the release of the offender would constitute an undue risk to society and meets other legal criteria for the decision being made; and
i. any special condition imposed and/or leave privileges, where applicable. Refer to the "Decision and Reasons" sections of policies 7.1 (Release Conditions) and 7.2 (Day Parole and Residency Leave Privileges) for additional information.

(http://www.pbc-clcc.gc.ca/infocntr/policym/polman-eng.shtml#p8_1)

These parole decisions are available to the public, albeit with all personal identifiers removed from the assessment. Accessing the decision registry has become a popular avenue for researchers and academics to access information related to the parole board member decision-making process (Mopas and Turnbull 2011). For PBC, providing access to the registry is seen as a means of being open and accountable to the public.

Structured Decision-making Framework

An abundance of research has criticized parole decision-making for inconsistency in the application of factors to be reviewed in the decision-making process (Grove and Meehl 1999; Grove, Zald, Lebow, Snitz, and Nelson 2000; Hutson 1982; Department of the Solicitor General

1973; Vantour 1986). Working within the parole system, Hutson (1982) conducted a comprehensive evaluation of parole decisions and made the case for the creation of a conceptual framework to guide decision-making. In the evaluation, he stressed the need for a set of guidelines that would not restrict the independence or the power of discretion for parole board members (1982, 254). However, it was not until years later that PBC implemented a structured framework.

Serin's (2011) structured decision-making framework is an effort to guide decision-making through a systematic process. According to Serin (2011), effective decision-making would be met by pursuing the following objectives: 1) consistency; 2) efficiency and accuracy; 3) quality decisions and reports; 4) increased level of comfort and confidence; 5) decreased liability in the event of false negatives; and 6) greater transparency (Serin 2011, 2). The decision framework encourages these specific components in order to guide decision-making.

The first step in the formula is to determine the actuarial risk level. Board members are reminded of the instruments that provide the greater predictive values, i.e. The General Statistical Information on Recidivism Scale–Revised (SIR-R) or the Level of Service Inventory-Revised (LSI-R). The manual also underscores that the use of more than one risk element does not equal a better prediction. According to Serin (2011), the "risk assessment becomes the anchor for the decision but is not the *actual* decision" (4). The second step requires the parole decision maker to conduct a case analysis that "considers pattern and seriousness of prior criminal and community supervision history" (2011, 4). In this section, the board member is to consider breaches of supervision whether or not the criminal history has become aggravating over the years, the offender's ability to control their behaviour, responsivity issues based on criminogenic factors, institutional behaviour, the evidence of change, and the proposed release plan. Finally, the framework is set up to allow the interview to be used as a forum to "ascertain" the degree of change or for clarification of various aspects of the file. The board members are provided with a worksheet and in order to structure and

facilitate analysis, an outline for parole board members to use when they write up their formal decision.

According to the four non-independent evaluative reviews of the framework (Gobeil, Scott, Serin, and Griffith 2007; Gobeil and Serin 2005; Serin and Scott 2006; Serin 2007), the framework has met its objective of reducing false positives and false negatives and has demonstrated to be have an 85% inter-rater reliability agreement (Serin 2011, 9). Although unpublished and self-evaluated, these studies provide empirical evidence that the aforementioned objectives seem to be met, especially with regard to consistent decision-making among parole decision-making. I argue however, that there are other factors to consider when analyzing parole decisions that the structured framework, in and of itself, fails to consider in its aim to streamline decision-making. Although it has been argued that this framework has been a critical component of improving quality decision-making, the following section will discuss other important contextual variables, not identified within the framework that that may also directly or indirectly influence decision-making.

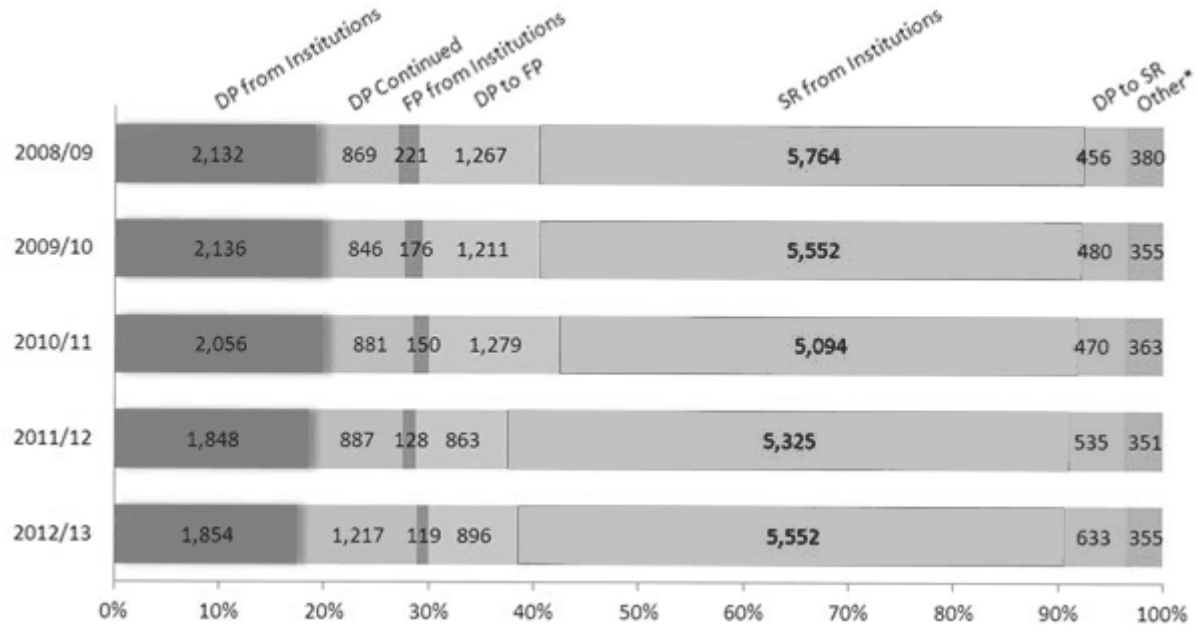
2.6. STATISTICS OF CANADIAN FEDERAL CONDITIONAL RELEASE

According to the PBC QuickStats on their website[14], there were 18 205 reviews (decisions) related to the release of federal offenders conducted by PBC decision makers in the 2013-2014 fiscal year. Of these, 4610 reviews were for the purposes of deciding day parole release (DP)and 3 491 were for full parole (FP) reviews. As seen in Table 1, the rate of DP and FP releases has continued to decrease over the last 5 fiscal years. Full parole rates decreased at a significant rate of 50%, which is connected to the increasingly prevalence of PBC continuing DP releases (as opposed to moving

[14] Reviewed 2015-09-14, http:/pbc-clcc.gc.ca/infocntr/factsh/parole_stats-eng.shml#3

DP cases to FP). Day parole to statutory release (SR) has also increased while revocation rates have been decreasing steadily over the past decade[15]. A staggering 52% of offenders were not considered for a parole release in the 2012/2013 fiscal year prior to their SR date. At the very least however, the reluctance to grant FP should be considered in light of these declining numbers. Table 1 depicts the federal releases from institutions and graduations from federal supervision periods:

Table 1 - Federal Releases from Institutions and Graduations from Federal Supervision Periods



* Includes releases from institutions at warrant expiry, at warrant expiry with a long-term supervision order, graduations from a federal supervision period to a long-term supervision order upon reaching warrant expiry, death, transfers to foreign countries, etc. (PBC Performance Monitoring Report 2014).

Zinger (2012) offers various reasons for declining rates of parole, i.e. access to programs; concordance rates between parole officers and parole board members; high numbers of waivers to postpone or waive parole decisions. Similarly, research jointly conducted by PBC and CSC (2009) also links the high numbers of waivers or postponements to declining rates of parole:

[15] http://pbc-clcc.gc.ca/rprts/pmr/pmr_2012_2013/index-eng.shtml#a53

> There are several circumstances under which a parole review for a discretionary release may not take place as scheduled. For example an offender may waive, postpone or withdraw an application for a parole review. A waiver is a written statement by the offender that renounces his or her legal right to a hearing and/or review by the PBC (Commissioner's Directive [CD] 712-1; *Corrections and Conditional Release Act*, ss. 123(2)). Generally, a waiver is valid until the next review date (two years) as required by legislation (*Corrections and Conditional Release Act*, ss. 123(5)). A postponement is a request made by the offender to delay a review or hearing and can be made any time before the review or hearing begins (CD 712-1). Postponements should not normally exceed three months (PBC Policy Manual, 2009). However, the Board may accept requests for lengthier postponements. An offender may also withdraw a parole review application to appear before the Board by submitting a request advising the Board that they no longer wish to be reviewed (Beauchamp, Cabana, Emeno, and Bottos 2009).

Gobeil (2012) builds on this issue of concordance rates between parole officers and parole board members in her unpublished dissertation. Using data over the past 30 years, she challenges research studies from Holland, Holt, and Brewer (1982), Carroll *et all* (1982), and Metchik (1988) and suggests that concordance rates are high not simply because both parties review the same data. She then draws attention to the research that suggests that recommendations by the institutional staff (especially negative ones), highly influence the parole board members' decision-making even when the information both parties receive is controlled.

Doob, Webster, and Manson (2014) also examine the declining rates of parole, shifting their focus to the legislative restrictions in the *CCRA* permitting decision-makers to grant parole based on probability that an offender will commit an offence prior to the end of their sentence as opposed to likelihood that the same offender will commit one after the sentence. These scholars empirically advance Brodeur's (1990) early prediction of the attrition of parole, the slow withering away of parole without a legislative decision to abolish it.

It is difficult to engage in a debate about the influences that contribute to declining rates of release, whether it is narrowing down the issue to concordance rates, access to programs, or legislative restrictions, without a comprehensive analysis of all these factors on decision-making. For example, consider that 52% of offenders did not apply for parole in the 2012/2013 fiscal year.

Concordance rates could only account for influencing the 48% of those offenders who did proceed with a decision for conditional release. Indeed, contextual reasons such as those identified by Zinger (2012) could account for the reasons that 52% of offenders postponed or waived their parole. These are all influences. The structured framework is also an influence on decision-making, however influencing the decisions relative to the sample of offenders who did proceed with a decision for conditional release. One could argue that the reasons the offenders did not apply for parole are just as important to consider in the decision-making process and reasons for declining parole rates. Unfortunately, access to offenders is restricted by the requirement for CSC approval.

Second, the absence of a scholarly or independent discussion of the influence of the framework on the decision-making process, is fundamentally problematic within the study of parole in Canada. In fact, the manner in which parole decisions are structured, written, and assessed over the past decade has conceptually changed. It is not surprising that concordance rates are high if we consider that the PBC and in 2009 CSC adapted the structured framework as part of a comprehensive implementation of the decision-making process. It could be argued that both parties are now relying on the same framework; they use the same worksheet to complete their analysis (or at least they are trained to), and both speak the same "risk" language because the framework informs and reinforces this process. In and of itself, concordance rates could represent a positive aspect of the implementation of the framework, in that high concordance rates could be indicative of better inter-rater reliability or it could simply suggest that there is greater consistency of a practical discourse.

Finally, the shift towards actuarially informed risk assessments has had a profound influence on decisions in criminal justice. As discussed above, the structured framework requires that parole board members anchor their decisions in the offender's actuarial score. Risk, represented in its actuarial form, acts as an organizing principle in the correctional decision-making process (Hannah-

Moffat 2004a, Hannah-Moffat 2004b; Maurutto and Hannah-Moffat 2005). In other words, an offender's actuarial score has a profound influence on eligible subjects. In fact, Zinger (2012) has questioned the value added of a parole board member's discretion in a process so influenced by actuarial risk scores.

This shift towards actuarially informed decisions is a defining characteristic in correctional decision making. Feeley and Simon (1992, 1994, 2003) argue that how the state governs, specifically how it governs crime and punishment is no longer focused solely on the rehabilitative ideal of the post war era but instead on a new form of post-modern punishment that is "concerned with techniques to identity, classify and manage groupings sorted by dangerousness" (1992 452). This new era of penology gives way to efficiency in the deployment of new techniques that target offenders as aggregate risk groups. Although the authors contend the *new penology* remains a viable heuristic device to explain a great many "practices" within the criminal justice process, there is a general gap in our understanding as to how mental health, namely within parole decisions, is understood and influences decisions in the *new penology*, especially in the Canadian parole context. This research endeavours to explore this area further to fill this gap in the research.

2.7. CONCLUSIONS

The points noted above draw attention to the complexity of criminal justice decision-making. I argue that parole decision-making is such a complex process that understanding decisions by their outcomes simply ignores an entire process of factors that feed into the decision-making process. A comprehensive review of the parole decision-making process is required if we are to understand how the culmination of various influences affect parole board members make decisions. The preceding chapter has detailed these influences, by tracing the evolution of conditional release in Canada. I have examined the tensions within the broader political field related to the role of

conditional release, and have linked these tensions to the changes in the legislative framework governing both corrections and conditional release policy. I have examined the influence of *The Criminal Law in Canadian Society*, the subsequent Correctional Law Reform and corresponding working papers, various commissions of inquiry, and parliamentary reports on the creation of the *CCRA*. The cumulative effect of this reform was substantial, both in its recognition of the rights of the offender and as well, within the institutional and organizational structure of the National Parole Board NPB (later renamed the PBC).

I have mapped out these penal reforms and discussed how correctional authorities and government agencies have framed and responded to growing challenge of offenders with mental health problems in prisons. I linked this growing concern of criminalization of the mentally ill with the deinstitutionalization movement. I have analyzed how these government documents framed the problem of the mentally ill offender as an issue of public safety. At the same time, these government documents suggest management strategies, namely rehabilitation, to manage the problem. This chapter has also noted how early reforms recognized the responsibility of the government for providing treatment to mentally ill offenders, albeit without actually defining "mentally ill". Before ending the first section of this chapter, I flagged the CLR's recommendation that decision makers draw on psychological assessments to ascertain the extent to which dangerous offenders were mentally ill and the potential threat to public safety.

The second half of this chapter examined the current effect of these broader reforms at the institutional level. I have described the various types of conditional release and detailed the organizational structure of the PBC. I have reviewed the relevant policies within PBC and CSC that mandate psychological assessments for violent offenders. This institutional structure and policy guidelines, as well as the PBC *Decision-Making Policy Manual*, can be located within the early reforms to improve correctional outcomes. I have discussed the role of the hearing and the decision-making

registry as hallmarks of an accountable and transparent government. I then analysed the statistics associated with declining rates of parole. I ended the chapter by suggesting that there has yet to be a satisfying explanation for declining rates of parole, as numerous factors appear to affect these numbers. I argue that the declining numbers cannot be understood without a larger examination of various institutional practices such as the new structured framework, as well as larger socio-political factors that influence parole decision-making, for example a shift towards actuarial risk decision making. I argue for an analysis that includes a review of both macro and micro level influences is required if we are to better understand how parole decisions are rendered, especially in relation to how mental health is understood in the decision-making process.

The next chapter will build on my argument for a comprehensive decision-making model to examine decision-making in the criminal justice system. Therefore, I will take a step back to examine various decision-making models at the theoretical level in order to substantiate my decision to rely upon a naturalist decision-making model.

Chapter 3. Theoretical Framework: Using Governmentality to Supplement a Naturalist Paradigm

The last chapter focused on the decision-making process. I examined declining rates of parole release and argued that the research that has examined these rates has taken a narrowly defined approach to examining parole-release decisions. I am of the position that these numbers represent a culmination of many factors that influence the rate of parole releases in Canada. These numbers not only reflect tensions within the system to process thousands of offenders through the conditional release process but also, they point to broader shifts in the governance of offenders. The latter argument will be expanded upon further in Chapter Four. Here, I present my theoretical framework as a "tool kit" robust enough to accomplish this. The objective of this chapter therefore is to map out my contribution to the literature on parole decision-making using Hawkins' (1986) conceptual decision-making framework, situated within symbolic interactionism. I supplement this analysis with concepts from the governmentality literature in order to move beyond an interactionist framework that aims to understand how people, in this case parole board members, have come to understand or give meaning to phenomenon through their interaction with others and institutional structures. An interactionist analysis does not however provide an adequate explanation of how systems of thought or organizational structures have influenced individual actors (Hacking 2004). Therefore, the linkage of the two theoretical frameworks is purposeful. In fact, I am borrowing from Hacking's seminal paper in which he argues that the two methodologies can be "complementary" and that an analysis

that combines both could provide a cohesive "top down" and "bottom-up" approach to understand the making up of the phenomenon being studied (277).

I will begin this chapter with a review of various decision-making models in order to position existing parole decision-making research within the respective theoretical paradigms. When I refer here to a "paradigm", I am drawing on Kuhn's definition of a paradigm as "the entire constellation of beliefs, values, and techniques, and so on shared by members of a given community" (1970 175). By examining these respective paradigms, I draw attention to the various ways these bodies of literature are invoked in decision-making research, and I use these paradigms as a heuristic compass to understand different aspects of parole decision-making (Abott 2004). Without a broad and comprehensive review, it is difficult to position myself, and relevant research, within the existing literature on parole decisions.

The following is an attempt at a thorough analysis of the three main bodies of research representing decision-making; i.e. the psycho-cognitive, the rational choice, and the naturalist paradigms. I will make the case that despite the various substantiated areas of research in criminal justice decision-making, a naturalistic paradigm is required to dissect the very complex, multiple layers of decision-making that is involved in parole decisions.

3.1. DECISION-MAKING MODELS

Far from being a unified body of research, decision-making models represent a complex inter-disciplinary field of study. Each field uniquely contributes to various ways of understanding of the decision-making process.

3.1.1. Psycho-Cognitive

Psycho-Cognitive psychology focuses on the behavioural and social aspects of decision-making. What is known from the psychological literature is that decision-making is often plagued by various systematic biases in our thought process - this is often referred to as mental strategies or heuristics that function as mental shortcuts. For example, judgemental heuristics refers to how people make routine judgements quickly in order to be efficient (Aronson, Wilson, Akert, and Fehr 2004). These heuristics are not necessarily accurate or the best option. However, they provide the mind with the opportunity to take in a great deal of information efficiently and continuously (Gigerenzer and Goldstein 1996). Availability heuristics are those mental shortcuts that refer to the ease with which someone can bring to mind available concepts or schemas[16] (Tversky and Kahneman 1973; Schwarz 1998). Adjustment heuristics are, "a mental shortcut that involves using a number or value as a starting point, and then adjusting one's answer away from this anchor: people often do not adjust their answer sufficiently" (Aronson, Wilson, Akert, and Fehr 2004; Tversky and Kahneman 1974). As well, automatic versus controlled thinking are important social psychological concepts that explain the ways in which we think. For example, automatic thinking refers to the way in which our thinking is unconscious and involuntary, versus controlled thinking which refers to making a conscious decision to think and reflect on a specific matter. As Aronson, Wilson, Akert, and Fehr (2004) suggest, controlled thinking is a method to rein in the "automatic pilot" in our thinking (86). Both automatic and controlled thinking lead to biases that reflect our assumptions about our social lives.

[16] A schema is "a mental structure people use to organize their knowledge about the work around themes or subjects; schemas affect what information we notice, think about, and remember" (Aronson, Wilson, Akert, and Fehr 2004, 620).

For those studying human behaviour, these concepts help understand decision-making. For example, Langevoort (1998) reviewed systemic biases and traced the influence of these on legal scholarship. In his review he identified how these specific types of interpersonal decision-making biases, concepts such as status quo / loss aversion biases, framing effects, anchoring and adjustment bias, illusory correlations and causation biases, risk perception biases, hindsight bias, intercontemporal bias, and egocentric bias influence and are taken into consideration at the level of judicial decision-making (1503). According to Langevoort, these systemic biases have had a huge impact on understanding how decisions are made in the judicial setting, as well as on how awareness of these biases influence judicial proceedings.

3.1.2. Rational Choice Model

Another dominant model of decision-making is the rational choice theory, a sub-section of economic or political science. According to Levin and Milgrom, "rational choice is defined to mean the process of determining what options are available and then choosing the most preferred one based on some consistent criterion. [It] starts with the idea that individuals have preferences and choose according to those. Our first task is to formalize what that means and precisely what it implies about the pattern of decisions we should observe." (2004, 1-3) As opposed to behavioural based models of decision-making (those found in psychology and cognitive sciences), rational choice theory assumes individuals will make rational, self-interested decisions, and that individuals will also make the most optimistic decisions based on available choices (Abell 2000).

However, as Simon (1947, 1976, and 1997) argues, people are not able to meet this level of rationality. Therefore, he adapted his understanding of rationality in decision theory. According to Simon (1997), because people are not able to review all available alternatives, they must choose the

most efficient and readily available alternative because they follow what he refers to as bounded rationality:

> The term 'bounded rationality' is used to designate rational choice that takes into account the cognitive limitations of the decision maker-limitations of both knowledge and computational capacity. Bounded rationality is a central theme in the behavioural approach to economics, which is deeply concerned with the ways in which the actual decision-making process influences the decisions that are reached (291)

Furthermore, because individuals rely on the most satisfactory as opposed to the most optimal alternative, Simon argues that individuals accept the less than ideal alternative routinely in order to make decisions (1997, 295).

Simon (1976) has also written at the level of the administration organization. For him, decision-making is a key to the success of any organization. He argues that decision makers are tasked to choose the best alternative between available choices and possible consequences and these decisions have a direct impact on the organization as a whole. Therefore, he suggests ways in which organizations can curb the discretionary bias or personal influence on decision-making within the organization, underscoring the importance of key design and implementation tactics. This task can be divided into three required steps:

1) the identification and listing of all the alternatives;
2) the determination of all the consequences resulting from each of the alternatives; and
3) the comparison of the accuracy and efficiency of each of these sets of consequences.

In an effort to influence decision-making within the work environment, it is therefore imperative to design the environment to foster the expected or desired outcomes for the organization with an overall objective of efficiency. For Simon (1976) there are five mechanisms an organization can use to influence its own functioning:

1) Authority: "the power to make decisions which guide the actions of another. It is a relationship between two individuals, one 'superior', the other 'subordinate'" (125)

2) Communication: "spoken word, memoranda, letters, records, reports, and manuals. Informal communication is built around the social relationships of the members of the organization." (157-162)

3) Training "prepares the organization member to reach satisfactory decisions himself, without the need for constant exercise of authority or advice […] Training is applicable to the process of decisions wherever the same elements are involved in a large number of decisions. Training may supply the trainee with the facts necessary in dealing with these decisions; it may provide him a frame of reference for his thinking; it may teach him 'approved' solutions, or it may indoctrinate him the values in terms if which his decisions are to be made […] Training is applicable to the process of decisions wherever the same elements are involved in a large number of decisions. Training may supply the trainee with the facts necessary in dealing with these decisions; it may provide him a frame of reference for his thinking; it may teach him 'approved' solutions, or it may indoctrinate him the values in terms if which his decisions are to be made." (170)

4) The criterion of efficiency: "demands that, of two alternatives having the same cost, that one be chosen which will lead to the greater attainment of the organization objectives; and that, of two alternatives leading to the same degree of attainment, that one be chosen which entails the lesser cost" (122)

5) Organizational identification and loyalty: the "process whereby the individual substitutes

6) Organizational objectives (service objectives or conservation objectives) for his own aims as the value-indices which determine his organizational decisions." (218)

This model is less useful however, in explaining the discrepancy due to discretionary bias that exists in organizational decision-making despite all the training, communication, efficiency designs and loyalty imposed on decision makers within an organization. Hawkins (2003) suggests that the rational choice model (as illustrated by Simon's theory) is problematic in describing the process of decision-making because decision-making is constructed into a scientific variable, removed from its natural setting, and isolated from its particular social context. The same critique can be made of the psycho-cognitive model of decision-making. It assumes that people will make decisions towards an outcome with little influence by environmental factors (Levin and Milgrom 2004). Moreover, in the case of parole release decisions, this optimizing approach frames parole decisions within an

input/output model that cannot account for the influences of the various larger socio-political factors a parole board member works is subject to when considering release.

3.1.3. Naturalist Model of Decision-making

The final model of decision-making I will review is the naturalist perspective. This perspective claims to be the most reliable approach to understanding the decision-making process. This model veers away from assumptions related to output or specific variables. Instead, it professes a more holistic view of decision-making, largely qualitative, and seeks to understand decision-making as a collective process, seen in its organizational, social, economic, and political context. According to the naturalist model, decision-making is a serial process. The analysis of decisions must consider the numerous actors engaged in the decision-making process well before the final decision is made (Hawkins 2003). Factors in the decision-making field necessary for analysis include a review of all actors, the political landscape, the economics related to the larger organization's population management, as well as the interpretive lens applied to parole decisions.

Hawkins' Conceptual Framework

Hawkins (1986) likens the decision-making process to "making up a mind" (1165). In discussing legal decisions, he explains:

> [It] is important to regard them as constituent parts of a continuous process which seamlessly connects one salient decision point with the next. Indeed, the process itself consists of an almost infinite number of complex decisions of greater or lesser significance about the handling or processing of a case *between* these salient decision points. Furthermore, some of these ancillary decisions, though less visible, may have significant consequences (1165).

He presents the legal decision-making process as linked to three organizing concepts: the *surround;* the *decision-making field;* and the *frame*. I will define Hawkins' concepts and will then discuss how these concepts make up a useful conceptual model for my purposes here.

Surround

In his early work, Hawkins' (1983) noted a void of interpretive work related to decision-making at the broader social political level[17]. Arguably, the dearth has been addressed by a steady growth of research on the larger ideological factors on decision makers within the criminal justice system (Cohen 1985; Garland 2001; Rose 1999), however, little that has examined parole specifically[18]. For Hawkins (2002), the *surround* represents the indirect or larger political climate or environment within which decision makers work:

> The surround in which both the regulatory agency and its regulated firms sit has political, economic, and social facets. As regulators conceive it, the surround may have an immediate and local character, or it may be remote. The surround is not, however, simply the setting for what might be termed naturally occurring undesired events. In its response to disaster, to changing public or political attitudes, or to shifts in the economic climate, government and media themselves becomes features in a regulatory agency's surround (115)

The *surround* has important features that are both political and economic:

> The character of the surround and its regulated population also serves as a context for the development of framing since it is the setting for the definition of an untoward matter as something warranting official attention (or not). This may in turn shape whether and how enforcement discretion is exercised. The surround is, therefore, intimately connected with the ways in which inspectors go about their work, and what sorts of decisions they make about enforcement when they encounter violations (124)

Hawkins' work relies upon a sociological analysis to examine the relationship of legal decision-making and the normative effects of the larger environment on decisions making within these organizations and institutions.

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[17] See Hawkins (1983) for further discussion on his references to this in particular.

[18] See Exercising Discretion edited by Loraine Gelsthorpe, Nicola Padfield for a review of collections of empirical studies that examine decision-making within the criminal justice system.

Decision Field

The *decision field* is understood as the second level of analysis in his model and is "the defined setting in which decisions are made". Hawkins (2003) argues that any analysis of decision-making must consider how the formal policies and formal law influence decision-making. He goes on to describe the linkages between the *surround* and the *decision field*:

> The decision field is a defined setting in which decisions are made. Decision fields sit within the social surround. While events in the surround are not open to control, the field, in contrast, is something defined by and acted on by the organisation. The law determines the contours and reach of the field of the criminal justice system by establishing and defining and mandate. The field also contains sets of ideas about how the ends of the law are to be pursued. These may exist at the formal level in the form of policies expressing the organisations mandate. But they also exist in an informal way in the way that values, expectations, and aims held by staff at all levels in the organisation (190).

For our purposes here, the *decision field* would include all the processes that support the PBC in their mandate and objective (as detailed specifically in the Parole chapter). The field considers the values identified in the mandate and the expectations of its employees, namely the parole board members in achieving their larger mandate. Finally, it considers the roles and responsibilities of parole board members and how these are operationalized in the decision-making process.

The organization relies on "patterns of guided interaction", which Manning (1986, 1293) underscores is the method by which the social reality of legal institutions shapes decision-making. By way of being highly ritualized, through carefully guided interactions, the parole board hearing is a mechanism by which parole board members' decisions are shaped. Interactions within the parole hearing are guided by rules that govern turn-taking, and in turn, shape the structure of the talk (Manning 1986, 1293). It is through this context that informal interactions within the hearing is sorted and given meaning by decision makers. Goffman's work on the Presentation of the Self (1959), is a useful lens to understand how the hearing is constructed through informal interactions. Goffman creates the metaphor of the theatre as a scripted stage performance in which actors relate

to one another in order to present their ideal self onto one another. The theatre creates reality through the additional use of props, social setting, and/or a scripted dialogue.

Frames

Hawkins' closely links his definition of a *frame* with Goffman's (1974) definition of frame, a question of "what is it that is going on here" (8). This level of analysis examines how actors organize content, code, and respond to facts. According to Hawkins', examining this level "frames the rules and principles that guide an understanding of what experience means" (190). As Hawkins goes on to explain, *framing* provides an explanation as to why a psychiatrist sees a problem from a mental health lens whereas a judge may look at the same situation and focus on the legal aspects of the problem.

With regard to parole decisions, it is the *frame* that "sorts the context" for parole board members. It is *framing* when a parole board member draws upon a file or considers data and conceives of a "risk" or a "mental health problem", as "manageable" or "compliant". I cite these concepts purposely as they are keywords drawn directly from my data set. They all represent or mean something based on the *surround* and the *decision field's* influence. This in part affects how the parole board member understands file information and makes decisions as part of the PBC organization and as an individual.

Hawkins' theory of decision-making situates itself within the larger symbolic interactionist framework, which focuses on how the process of social interactions constructs meaning. Mead originally coined this perspective in the 1920s, but Blumer later expanded upon the theoretical framework, symbolic interactionism. For Blumer, there are four basic tenets of the symbolic interactionist perspective. First, individually and collectively, people act according to the shared and subjective meaning given to objects (Blumer 1969, 50). As noted by Baugh (1990) research must therefore aim to get at the meaning from the standpoint of the participants (41). Second, social

interaction is a process of indicating and interpreting the other person; interactions are fluid and variable (41). Third, social action is a process by which "actors note, interpret, and assess the situations confronting them" (50). He goes on to describe that research here must focus on the process of action from the perspective of the actor and how the actor interprets information in order to act upon (42), Finally, social organizations represent collective arrangements of people interlinked with their own standpoints, meanings, and interpretations (58).

Hawkins' work in particular draws on Erving Goffman's (1974) frame analysis, which essentially provides the larger infrastructure of Hawkins' theoretical legal decision-making framework. Goffman's frame analysis is a study in the understanding of how people make sense of situations based on their lens or belief system. In other words, frame analysis provides a cognitive instrument that allows people to determine, "what is going on" within a particular context (11). He goes on to explain that "when the individual in our Western society recognizes a particular event, he tends, whatever else he does, to imply in this response (and in effect employ) one or more frameworks or schemata of interpretation" (21). People actively project their assumptions onto the world around them, interacting with others in a process that either confirms or transforms their projections. These assumptions are also how individuals interpret events or conceptualize experience. Goffman's work is also critical for understanding how individuals take in large amounts of information, draw on what is important to them, filter out "noise" with a view of determining a decision. This is all, as per Goffman, an exercise in cognitive filtering and it guides how people understand reality. The concept of frames is the umbrella for Hawkins' decision-making theory.

Hawkins (1986) also advances that determining the "*facts"* in a particular case is, in and of itself is, a complex and subtle process that influences decision-making (1178). He goes on to say that *"facts'* are themselves products of human choice and judgment, since they are comprised of mosaics of a multitude of decisions made earlier in the creation and processing of the case" (Hawkins

1986, 1179). Moreover, *facts* of a dossier are intimately linked with the larger policy related decisions in order to determine what is important to pay attention in a particular case.

Overall, these various decision-making models present rather different points of inquiry and consequently, produce vastly different interpretations of decision-making. The next section will review the existing body of literature that examines parole decision-making directly. This examination will further deconstruct the parole decision-making process and critically analyze the findings from a naturalist perspective.

3.2. RESEARCH ON PAROLE DECISION-MAKING

There is an abundance of literature on parole decision-making, primarily studied through the psycho-cognitive model. This type of analysis, often quantitative, focuses on various "factors" and purports to measure these factors in relation to the decision outcome. For example, numerous studies have identified factors that appear to influence parole board decisions. Studies have identified factors understood by parole authorities as relevant to the decision-making process such as: institutional recommendations (Daly 1994, Morgan and Smith 2005); offender typologies (Sudnow 1965, Silverstein 2006); prior criminal record (Meyer 2001); supervision programs (Petersilia and Turner 1993); and mental health (Feder 1994, Matejkowski 2011, Porporino and Motiuk 1995).

Many studies also identify the influence of extra-legal factors on the parole decision-making process. Extra-legal factors are those not legitimized through the standardized decision- making process and could be construed as extraneous information. Many of these have been identified in the literature: gender (Silverstein 2006, Hannah-Moffat 2004a, Hannah-Moffat 2004b, Steffensmeier and Hebert 1999); victim participation (Morgan and Smith 2005, Polowek 2005); dynamics among

parole decision makers (Conley and Zimmerman 1982); offender age (Huebner and Bynum 2006); In one recent study, simply providing the decision maker with a food break appeared to influence the decision (Danziger, Levav, and Avnaim-Pesso 2011).Some studies have found that we can learn about parole decisions by studying parole board member characteristics (Kingsnorth 1969; Wilkins 1975; Wilkins, Gottfredson, Robinson, and Sadowsky 1973; Samra-Grewal and Roesch 2000; Gottfredson and Ballard 1966). After studying parole board decisions, Gottfredson, Wilkins and Hoffman (1978) argue that decision makers can be grouped into four categories: the sequentialist, the "ah yes!" the simplifier, and the ratifier. These authors argue that personal perspectives or frames of reference common to each category will have an inevitable effect on decision-making. I would argue that creating typologies to fit parole board members into a neat little box is perhaps disadvantageous as it does not capture the unique, nuanced or even complex social environments within which each parole board member may make a decision.

Variable-outcome based psycho-cognitive analysis studies can be particularly misleading in that the studies detach decision-making from the context in which it was rendered, measuring outcome-based decisions through a closed system that postulates a link between input and output data. In these studies, numerical values are assigned to variables, which are then understood by the final decision's outcome. Arguably, there are various and often competing factors beyond those found at the institutional level that influence a parole board member's decision when considering parole release (Cohen 1985; Garland 2001; McCleary 1992; Feeley and Simon 1992). I argue that there is a general failure of these studies to identify consistent, reliable predictors of outcome. This is not surprising if we consider the discussion in the last chapter regarding declining parole rates, and difficulty in locating the precise factors that are contributing to the decline. There are many micro and macro level influences on the decision-making process that postulating a link between a factor

and outcome seems inadequate. It is worth noting that many of the variable outcome based studies have identified this methodological shortcoming in their research. Here are a few examples:

1) "Although the Nebraska system of parole uses dual hearings, it seems reasonable to suggest that other systems operate within a similar structure albeit informally. Future research should address these formal and informal decision points" (Proctor 1999, 213)

2) "This study clearly illustrates that an empirical analysis of final decisions alone is inadequate for studying parole process in groups such as parole boards. Such policy studies require extensive observations of the group in question to direct the empirical analysis to important subgroups and disaggregation" (Conley and Zimmerman 1982, 429)

3) "It is unclear to what extent impressions gleaned from release hearings influenced release decisions in the current study. Results may indicate that the operationalization of risk factors used in the current study did not adequately reflect the operationalizations used by the board members" (Matejkowski 2011, 4)

A naturalist model would move beyond the existing factor to outcome analysis to include larger contextual influences in Canadian parole decision- making. For example, Padfield, Liebling and Arnold (2005) assess how a setting of public visibility affects decision-making, the offender's interaction with parole board members, and parole registry decision records. The result is a comprehensive analysis of how a culture of risk aversion (ideology) affects parole release decisions of offenders serving a life sentence. This deconstruction of the process clearly differs from studies that link variables with outcomes by analyzing all actors in the decision-making process, political landscape, and the organizational pressures in order to highlight how influential all these factors are in the decision-making process. However, building on the points noted in the previous chapter, the

authors' map out aspects of parole decision-making in order to understand a total effect of the discrepancy on the rates of release of lifers within their data sample.

3.3. MENTAL HEALTH AND PAROLE DECISIONS

The same critical standpoint can be extended to the existing research on mental health and parole decision-making. A small body of quantitative research that has studied parole release decisions found discrepancies between parole decision outcomes for offenders with and without mental health problems (Porporino and Motiuk 1995; Feder 1994; Hannah Moffat 2004; Ditton 1999; Fitzgibbons 2007, 2008). As outlined in Chapter Two, this discrepancy is often referred to in the literature as "differential treatment" (Feder 1994, 408), inferring that mental health problems negatively impact parole decisions, reducing the likelihood of offenders with mental health problems being released into the community.

With the exception of Hannah Moffat's (2004) study, the few studies that have investigated mental health and parole decisions have done so through quantitative outcome based analysis model, examining the relationship between mental health and parole release decisions through statistical analysis. For example, Feder (1994) investigated how psychiatric hospitalization affected the likelihood of being granted parole and found that, after she controlled for other extralegal factors, incidents of psychiatric hospitalization during incarceration had the largest impact on parole release. She found that offenders who had not previously required hospitalization were 30 times more likely to be paroled (404). Similarly, Porporino and Motiuk's (1995) argued that their review of outcome parole statistics supported the differential treatment claim. These authors argue that offenders with mental health problems serve longer proportions of their sentence imprisoned, are more likely to spend their time within prison at a higher security level, and are less likely to be

granted various forms of conditional release[19]. However, as aptly noted by Porporino and Motiuk (1995) and Feder (1994), this effect could also be explained by other covariates, such as contextual factors like lack of programming or services in the community to offer supervisory or support services to the offender on parole that perhaps influenced parole board members and made them reluctant to release to the community.

I argue that a naturalist analysis has the capacity to add to the dynamic understanding of the parole decision process and move beyond an outcome based examination. A naturalist model would allow linkages within the shifting ideological currents that I referred to in the previous chapter on parole (i.e. tough on crime ideology; rehabilitation discourses within legal frameworks), or other relevant symbolic, socio-political, economic, and organizational constraints placed on decision makers. This theoretical model provides a lens to better understand the unique Canadian federal level decision field, such as the influences of organizational priorities to increase PBCs and CSCs respective organizations' capacity to meet the needs of offenders with mental health problems. Moreover, the model also forces one to examine how individual criminal justice professionals understand mental health in the assessment and decision-making process. When all these socio-organizational and individual factors are considered, the link between mental health and parole decision-making can be better understood.

3.4. THEORETICAL CONTRIBUTION

This section will detail my theoretical toolkit, so to speak, mobilizing the governmentality literature to shed new insight into the area of parole decision-making. As I discussed in the previous

[19] Of note, these authors also found that offenders with mental health problems are more likely to have their conditional release revoked for technicalities than offenders without "major mental disorders" who commit new offences while on conditional release.

section, Hawkins' research relied specifically upon a sociological analysis of actual events within the *surround* to inform his analysis on decision-making research. In his own analysis of the surround, he traced major events and/or natural disasters in the 1980s that caused specific political concerns (railway accident, explosion and fire at oil rig, the collapse of a newspaper company), and he analyzed this effect on how professionals made regulatory decisions (2002, 49). Through his analysis, he underscored how these events in the surround affected, characterized and regulated the actors within the surround.

As an alternative to a conventional macro level sociological analysis, I will draw on the governmentality literature as a way of characterizing parole decision-making. According to Garland (1997), a governmentality analysis does not pose specific questions insofar as it attempts to make sense of the present arrangement. As Garland points out, the governmentality literature provides a method of analyzing penal and strategic *patterns* of governance in postmodern society in order to understand how these *patterns* have come to influence institutions, such as those within the criminal justice system. He emphasizes governmentality's focus on power and knowledge as a relevant, compatible and informative theoretical body of research (Garland 1997, 204). I argue that an analysis of how these *patterns* in the surround influence the institutional, organizational, and/or individual level will provide a comprehensive contribution to the literature on parole decision-making.

Governmentality and Risk Rationalities

Foucault coined the term governmentality in the 1970s in his exploration of the relation of power, truth/knowledge, and governance. His work focused on knowledges, beliefs, and discourses as a "study of the organized practices, [or assemblages] through which we are governed and through which we govern ourselves, what we shall call *regimes of practices*" (Dean 1999, 18). Within a governmentality framework, *regimes of practice* are analyzed to expose ways of thinking or

understanding the world, referred to as *rationalities*, and ways of acting out those rationalities, referred to as *technologies* (Garland 1997). According to Garland (1997), "rationalities are thus practical rather than theoretical or discursive entities. They are forged in the business of problem solving in an attempt to make things work. Consequently, they manifest a logic of practice, rather than of analysis, and tend to bear the hallmarks of the institutional settings out of which they emerged" (184).

A governmentality analysis is not concerned so much with why governance is orchestrated the way it appears but rather how the state exercises governance, rendering visible how issues of concern, social issues, or problematics are framed and how government for the most part, "directs" human behavior or "conduct of conduct" of its citizens (Foucault 1991; Rose, O'Malley and Valverde 2006; Dean 1999). This type of analysis relies on a particular line of questioning to understand the relation of power in governance; it questions how a phenomenon or problematic has come to be by tracing the history of the particular social problem through a genealogy of rationalities to see how we arrived at a specific form of governance.

These rationalities rely on discourses, defined as "a bounded body of knowledge and associated practices, a particular identifiable way of giving meaning to reality via words or imagery. Through discourses, we perceive and understand the social, cultural and material world in which we move. Discourses both delimit and make possible what can be said and done about phenomena such as risk" (Douglas 1999, 15)

Risk rationalities are intimately linked to neo-liberalism, a political governance framework that rests upon the assumption that individuals are responsible for their own wellbeing. Under this framework governance is restructured away from a welfare (or utilitarian) emphasis and its top down regulation of the population. Neo-liberal strategies of governance rely upon actuarial data in a system of risk assessments in order to govern populations (Garland 1997). I will discuss risk

rationalities in the following chapter in my discussion of risk as an organizing principle; but for my purposes here, I emphasize the importance of risk rationalities as a form of power in the regulation of neo-liberal society.

Foucault understood power, and characteristics of power, operating at the level of *rationalities*, *techniques* and *discourses*. This is a non-conventional way to consider power. Power is no more something that is possessed solely by the political head, but rather power is something that is found in the patterns, domination, and subordination at the level of social relations (Garland 1990, 138). In this context, power is a productive mechanism as opposed to authoritarian, operating in a "net like organization" through individuals not against, and that which "help[s] constitute the individual who at the same time its vehicle" (Garland 1990, 138).

Power materializes within *discourses* and is best understood by its effects on these relations (Foucault 1991, 39). This is because discourses are heuristic "linguistic" devices, they shape how power is being thought about and acted out (Rose and Miller 1992). Discourses are not set up in a hegemonic relation, in which one discourse dominates others rather multiple discourses circulate within strategies and in accordance with the context in which they are located (Foucault 1978). For Foucault, discourses create "truth" by the "establishment of domains in which the practice of true and false can be made at once ordered and pertinent" (Foucault 1991, 79). In other words, discourses perform or create truth by the very act of stating so. Discourses of truth are pertinent to an understanding the "how" of power".

Penal practices and/or penal styles are linked to modes of power systems rooted in their economic functionality (Castel 1995/2003; Garland 1990); prisons fit into that larger power system, acting as an apparatus to produce new knowledges that contribute to power systems. New discourses produced by the creation of new knowledges interact with existing,

sometimes conflicting discursive ideologies and this results in often competing objectives within governance strategies.

Foucault's work focuses specifically on modern governance's evolution since the 15th or 16th century. He identifies three specific but interwoven models of power that has dominated strategies of control: *sovereign, discipline* and *government*. Each of these models of power corresponds with specific *rationalities*, *technologies* and *discourses* that characterize the era.

Models of Power in Governing

Sovereign Power

In feudal times, the absolute rule of power was through the divine right of the king. The king was the absolute ruler and had complete power over the state and the bodies of his subjects. He possessed power, and maintained power over his territory by controlling his citizens by ruling over them. Foucault uses the text from Machiavelli's *The Prince* to present his position that the mechanism of power pre-capitalism was ensured through the sword and obedience.

Due to particular points of changes in humanitarian reform within the late 1700s and early 1800s, there was a movement away from a form of government in which the purpose of the monarchy as a ruler was to protect and strengthen its territory. Sovereign power as an analytic model could no longer account for the strategy of governance. Knowledge about the population became a key strategy to manage/govern the population. In order to maintain control over the population, while adhering to the social contract, a new relation of power emerged with strategies geared at *knowing* the population through various means, i.e. statistics regarding the population's health and wellbeing. A new rationality in the art of governing was conceived of in which power was no longer something that could be possessed, the ruler

of the territory was no longer external to what was ruled, but rather the concept of politics became separated from the concept of economy. A political economy[20] became the *raison d'etre.*

Disciplinary Power

Disciplinary power became a dominating *rationality* in the art of governing, striving to maximize individual productivity. In this sense, power was seen as productive, not repressive, and was aimed at producing disciplined or docile bodies to the aims of the state. As Foucault notes, "'[d]iscipline' may be identified neither with an institution nor with an apparatus; it is a type of power, a modality for its exercise, compromising a whole set of instruments, techniques, procedures, levels of application, targets; it is a 'physics' or an 'anatomy' of power, a technology" (1977, 214). As early as the 16th century many institutions such as hospitals, military and school began to rely upon techniques of power such as observation, normalization, and assessment to know individuals, to render them docile and produce or socialize disciplined citizens. By the 19th century this form of power had infiltrated the realm of the social, regulating larger society through institutional forces and disciplinary techniques of governance. Power within this political *rationality* is understood in its effects as the population emerges as the essential object known and targeted for governance.

Government

Emerging from the disciplinary society, Foucault referred to the modern art of governing as government or *bio-power* (society of normalization). Where Foucault understood

[20] Foucault describes a political economy as being "the correct manner of managing individuals, good and wealth within the family (which a good father is expected to do in relation to his wife, children and servants) and of making the family fortunes prosper-how to introduce this meticulous attention of the father towards his family into the management of the state" (Foucault 1991, 92).

disciplinary power as localized and focused on individualizing the individual, *bio-power* is understood as a technique geared at collectively socializing the population as a group. As noted above, governmentality focuses on the "population" as well as the "body" as its sites of governing. *Bio-power* places emphasis on the health of the population, risks to the population, and/or employment of the population (etc), implicating a further reliance upon the human sciences ("psy") disciplines and the "technical means to appropriate to it" (Dean 1999, 20). Within this model of power, the state retracts and regulation is omnipresent, both the self and the population exercise power and regulation because essentially the population has been governmentalized to do so.

Rose's (1996) work extends and develops the notion of modern power, arguing that there has been a re-figuring of the methods in neo-liberal governance. He argues there is a new "emphasis on the personal responsibilities of individuals, their families and their communities for their own future wellbeing and upon their obligation to take active steps to secure this" (328). He claims that liberal rule has become dependent on a whole range of other legitimized authorities who upon forging alliances with the state, take part in the governance of the population.

"Psy" knowledges play a privilege role in the larger psy complex, aiming to influence and regulate the population through *technologies of the self*, in large part by a language of judgement and the establishment of norms of conduct. According to Rose, the role of diagnosis and assessment by psy experts is in integral part of this regulation and explains how modern populations and individuals are constituted. As explained by Rose (2000):

> The significance of psychology within advanced liberal modes of government lies in the elaboration of a know-how of the autonomous individual striving for self-realization. In the nineteenth century, psychological expertise produced a know-how of the normal individual; in the first half of the century it produced a know-how of the social person. Today, psychologists elaborate complex emotions, interpersonal and organization techniques by

> which the practices of everyday life can be organized according to the ethic of autonomous selfhood (90).

Psy knowledges play an important role in managing vice or social problems, emphasizing the unique role that diagnosis and assessment by psy experts play in the regulation of risky or immoral populations. In fact, Rose (1999) refers to psy experts as "control workers", and situate their administrative function in the governance of risky populations, those whose risk is deemed so high that incapacitation, strategies of exclusions are used to control their perceived risk. The role of diagnosis and assessment is critical in the constitution of the permanently risky and in their management of exclusion (Rose 1999, 332). For Rose, psy knowledges and diagnostic labels feed into this shift towards risk thinking. For him, risk thinking is a central feature of decision-making processes in the regulation of risky populations in neo-liberal society for those who cannot be managed in the absence of control strategies.

Rose (1999) distinguishes between the two different populations in neo-liberal control societies[21]. Those populations that can be affiliated back into the community through inclusive strategies such as programming, treatment, or surveillance measures and the other population: the disaffiliated or abject. According to Rose (1999), the affiliate is the active citizen who through their life choices have illustrated that they can manage themselves, and have aligned themselves as good responsible moral individuals. The disaffiliated on the other hand, are subject to exclusionary strategies and constituted as morally flawed, understood as irresponsible and not able to regulate themselves through the usual avenues of power that

[21] Castel (1998, 1991) underscores the role of expertise in this power structure, occupying a privilege role in the targeting of 'at risk' populations, arguing that the interpretation of the expert dominates perceptions of the individual. The individual in other words, becomes the label they are assigned and based on these designation as flawed, abnormal, risky or dangerous, are subject to preventative strategies of social control.

percolate in modern society. Within this group of disaffiliates, there are two subsections of populations: those who can be made into being responsible and regulated back into society and those who are deemed unsalvageable (labelled as risky or dangerous).

Drawing on this body of literature as well as key concepts from Hawkins' and Goffman's interactionist framework, this research will examine how mental health is understood, constructed, and regulated through modern governance strategies of control of marginalized populations, i.e. offenders. I seek to contextualize how these strategies infiltrate the decision-making process, and explore how individual actors draw upon mental health and the extent to which it is understood as a problem in the release process.

3.5. CONCLUSIONS

This chapter has examined various models of decision-making with a focus on criminal justice decisions: the psycho-cognitive, the rational choice, and the naturalist paradigms. I argued that a comprehensive decision-making model is critical to examine parole decision-making and despite the various substantiated areas of literature on decision-making, a naturalistic parading is required to dissect the very complex, multiple layers of decision-making that is involved in parole decisions. Without an understanding of these different areas of research, it is theoretically difficult to challenge the literature that measures parole decisions based on outcomes. I challenged the notion that the studies of parole decision-making do not necessarily yield an accurate representation of the decision-making process, especially since they fail to predict reliable consistent outcomes, particularly because the studies are removed from the context from which they were studied. Based on these points, I argue that if I am to understand how mental health is considered in the complex process of parole decision-making, I need to examine the macro and micro levels of influence on the criminal justice decision-making process.

In this chapter, I have also detailed my theoretical toolkit. I established Hawkins' naturalist model of decision-making as an optimal framework for the proposed analysis. Although Hawkins' research relied specifically upon a sociological analysis of actual events within the *surround* to inform his analysis on decision-making research, I argued that the governmentality literature and its concentration of power and the management of problematic populations is an optimal lens to consider when analysing penal patterns within the surround. The next chapter will build on this chapter by deconstructing the concept of risk, illuminating the differences in the realist and governmentality conception of risk.

Chapter 4. Risk as an Organizing Principle

Before I advance to my methods, I wish to establish and position myself within the risk literature. Although decision-making is the primary concept in this study, no understanding of parole decision-making can be had without an understanding of the concept of risk. Risk is such a central concept in modern society that it seems unnecessary to state that we are governed through risk. Yet, in recent years, scholars have increasingly problematized the concept of risk (as an organizing technique) for its incoherence in institutional applications (O'Malley 2004; Hannah Moffat 2004a). While most would agree that we have moved towards a risk society, there is much debate as to how risk strategies have evolved (Hannah Moffat 2004a) and the diverse configurations in which risk is deployed (O'Malley 2004).

Despite the vast amount of theorizing on "risk", there is yet to be a unified and precise theory that explains the concept. This can be explained, in part, by the cross disciplinary or ontological differences in the range of theoretical perspectives that are linked to "risk" (Taylor-Gooby and Zinn 2006); as well as various changes in the meaning of the concept over the past century (Lupton 1999). As Garland notes, "what is sometimes referred to as 'the risk literature' is in fact several distinct literatures, involving different projects, different forms of inquiry, and different conceptions of their subject matter" (2003, 49).

The present chapter is an effort to theoretically engage with the large body of risk research and position myself and the organizations implicated in parole decision-making (i.e. PBC and CSC) within that literature. Here I will draw on the work of Lupton (1999) who characterizes the risk

literature in terms of categories position along a realist/constructionist continuum (Lupton 1999; Taylor-Gooby and Zinn 2006). The perspective that emphasizes a technical and scientific approach falls on the realist end of the continuum, with "risk society" theorists or weak constructionism perspectives in the middle of continuum, while governmentality theorists fall at the other end of the continuum (emphasizing a strong constructionist perspective). I mention this middle part of the continuum in order to be thorough. However, I do not expand on this perspective in my dissertation as it is a macro level analysis that is not necessarily conducive to the scope of this research. By examining differences among the perspectives, I can draw insights central to all the various perspectives[22]. However, as described in the last two chapters, since my theoretical toolbox consists of a merging between the symbolic interactionist and governmentality perspectives; I assume a constructionist perspective while the documents I analyze in this research (produced by PBC and CSC) construct the offender through a realist perspective. This is a very important point, and takes considerable effort to ensure consistency and remain methodologically and theoretically sound throughout this dissertation. This chapter therefore examines the risk literature, from different ontological and epistemological positions, and describes the concepts and analytic tools used within the literature that characterize each perspective.

4.1. THE REALIST PERSPECTIVE

Risk, according to the realist perspective, is the product of a statistical probability associated with a hazard or danger (Bradbury 1989, 382). Contrary to the belief that risks are socially constructed, this perspective assumes that risk can be identified, managed, and prevented with

[22] For example, Lupton (1999) has noted that all social constructionist positions on risk agree that "risk has become increasingly pervasive concept of human existence in western societies; risk is a central aspect of human subjectivity; risk is seen as something that can be managed through human intervention; and risk is associated with notions of choice, responsibility and blame" (25).

known precise accuracy. Institutions that are required to weigh the possibility of harm against a desired outcome use this perspective. The reasons can be summed up twofold: first, the scientific response can be influential in its claims that the organization's ways of anticipating and addressing risks are objective and rational (Sparks 2001). The appeal of the scientific perspective to respond to the problem of risk is that research is presented as "empirical" and such scientific discourse lays claims to *truths*, as it carries the "'gift' of objectivity" (Taylor, Walton, and Young 1973, 33).

In this model, lay knowledge is "inferior" to the scientific literature, allowing institutions to rely upon "science" or *truths* to defend their risk related responsibilities (Lupton 1999). Second, the assumption is that if undesirable behaviours are predictable then better resources can be directed towards minimizing the "predicted" negative behaviours (i.e. reoffending) (Feeley and Simon 1992).

In Canadian correctional policy, risk is determined through actuarial assessments that conceptualize conceptualize populations of offenders as "risk subjects" (see Andrews and Bonta 2006; Andrews, Bonta, and Bonta, and Wormith 2006). The crime control industry has come to rely primarily on risk based governance governance (Feeley and Simon 1992; 1994; Hannah Moffat 2004a; 2004b; O'Malley 2004; Roberts 2001). Risk 2001). Risk strategies related to the realist perspective rely heavily on the psychometric paradigm, which which conceptualize the "offender" as a "real" or "objective" (as opposed to a perceived) risk to public public safety. In Canada, this shift towards risk management and risk assessment is informed by a body of body of literature that reinforces the notion of the role of science in risk assessments. Evidence based based correctional practice (EBP) is, "the body of research and replicable clinical knowledge that describes describes contemporary correctional assessment, programming and supervision strategies that lead to to improved correctional outcomes such as the rehabilitation of offenders and increased public safety" (Serin safety" (Serin 2005, vii). The research that has flowed from EBP has identified a set of risk factors associated associated with criminal recidivism. The following table outlines these risk factors:

Table 2 - The seven major risk/need factors (Andrews and Bonta 2007)

Major risk/need factor	Indicators	Intervention goals
Antisocial personality pattern	Impulsive, adventurous pleasure seeking, restlessly aggressive and irritable	Build self-management skills, teach anger management
Pro-criminal attitudes	Rationalizations for crime, negative attitudes towards the law	Counter rationalizations with pro-social attitudes; build up a pro-social identity
Social supports for crime	Criminal friends, isolation from pro-social others	Replace pro-criminal friends and associates with pro-social friends and associates
Substance abuse	Abuse of alcohol and/or drugs	Reduce substance abuse, enhance alternatives to substance use
Family/marital relationships	Inappropriate parental monitoring and disciplining, poor family relationships	Teaching parenting skills, enhance warmth and caring
School/work	Poor performance, low levels of satisfactions	Enhance work/study skills, nurture interpersonal relationships within the context of work and school
Pro-social recreational activities	Lack of involvement in pro-social recreational/leisure activities	Encourage participation in pro-social recreational activities, teach pro-social hobbies and sports

Table 3 - Minor risk/need factors (Andrews and Bonta 2007)

Non-criminogenic, minor needs	Indicators
Self-esteem	Poor feelings of self-esteem, self-worth
Vague feelings of personal distress	Anxious, feeling blue
Major mental disorder	Schizophrenia, manic-depression
Physical health	Physical deformity, nutrient deficiency

As seen above, mental health is a minor predictive factor for recidivism within the realist risk paradigm suggesting that mental illness or mental disorder should hold little value in risk assessments.

These risk factors are targeted in risk assessments. The evolution of risk assessments falls into four historical categories. These are referred to as the four generations of risk assessment. According to Bonta (1996), the first generation (1G) of risk assessments relied primarily upon clinical or

professional judgements; however, 1G assessments were found to be insufficient in their predictive value (Lowenkamp, Holsinger, and Latessa 2001). Second generation assessments (2G) relied upon specific static variables[23] in the "offenders" file. The third generation (3G) of assessment tools were advanced as empirical and theoretically driven (Andrews and Bonta 1995). These tools relied upon dynamic risks, static risk, and criminogenic needs, and are used the general personality and social psychology of crime as their theoretical lens (Andrews, Bonta, and Wormith 2006). Currently, fourth generation (4G) risk assessment have grown out of the evidence-based correctional practice (EBP).

EBP has identified guiding principles for correctional interventions. These principles are referred to as Risk, Need, and Response and constitute the RNR model, which is used to inform Canadian correctional interventions. The logic behind the *risk principle*, the *need principle*, and the *responsivity principle* is as follows: identify risk, match level of intervention to the risk level, and assess and target criminogenic needs in a rational manner in order to maximize treatment gains to rehabilitate the offender and manage risk to the public.

Within a paradigm that considers the "scientific" understanding of risk as superior to other theoretical positions, it is difficult to dispute the influence of the realist risk paradigm on Canadian correctional practices. One could argue that they have been revolutionary on an international level in informing correctional interventions. Notwithstanding the problems surrounding the claim that risk assessments are solely based upon pure logic, numerous scholars have called into question this technical discourse of risk (Kemshall 1998, 2000; Hannah-Moffat 2004; Horlick-Jones 2003, 2005; O'Malley 2004). These theorists point to issues with regard to the validity of empirical "risk" assessments and tampering or translation issues by frontline or social agents. However, as Silver and Miller (2000) have found, the renewed appeal of statistical prediction tools over the past few decades

[23] A static variable is one that "does not change or changes in only one direction" (Bonta 2002, 367).

are rooted in its ability to aggregate the ever-increasing populations of offenders by assigning risk among population subgroups as opposed to investing an individual assessment model ideographically. Some have argued that risk techniques mask the politics that influence and shape how offenders are controlled (Schneider and Ingram 1993; Silver and Miller 2000).

4.1.1. Actuarial Justice

The shift towards risk logic to predict future harm within the criminal justice system is associated with what is routinely referred to as "actuarial justice". According to Roberts (2005), actuarial justice has greatly influenced the field of criminal justice, relying upon concepts and methods used in actuarial mathematics to evaluate risk and dangerousness of offenders.

Risk plays a central role in actuarial justice. Since 1978, the law related to Canadian parole has been on a trend towards twin track policies that have increasingly operated under the "risk criteria" (Roberts 2001)[24]. Roberts[25] found that the tendency toward risk-informed policies led to the targeting of "hard" versus "soft" offenders, hard and soft defined not necessarily based on the level of violence or severity of offence but risk. Low risk offenders or soft offenders are more likely to be granted parole and provided rehabilitation, and high risk or "dangerous" offenders are managed through increased risk management strategies (incapacitation). Roberts argues that the strategies to differentially manage low and high risk offenders is evidence of twin track policies, and links her

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[24] Simon wrote in "Ideological effects of Actuarial Practices" that "the success of actuarial methods in shaping a new ideological basis for the governance of social life will be marked by its ability to colonize legal discourse with its representations. Law is one of the primary ways in which a sustained effort is made to rationalize choices about which solutions should be employed to manage social problems. Laws do this by subjecting social practices to an inquisition that demands the manner of representation be justified and generalized" (1988, 775).

[25] Roberts (2001) also argues in her research that offenders are increasingly released on parole because the law, by way of their eligibility date, dictates that they are to be released, not necessarily because they are rehabilitated.

work with other authors such as Cohen (1985) who detailed the implications of the bifurcation of crime policies in the larger spectrum of social control. According to Cohen, two visions of social control have emerged in recent decades; inclusion versus exclusion practices[26]. Within this dynamic, prisons are used to exclude offenders who are deemed too risky to release to the community and the community is an option for softer or less risky populations:

> The real master shift about to take place is towards the control of whole groups, populations and environments-not community control but the control of communities. In this movement to technology and resources, particularly at the hard end, are to be directed to surveillance, prevention and control, not "tracking" the individual adjudicated offender, but prevention surveillance […] of people and spaces. (Cohen 1985, 127)

These twin track policies or bifurcation of crime policies are understood as processes of *selective incapacitation*[27]. In the above examples, Roberts (2001) and Cohen (1985) deconstruct the implications of actuarial justice practices to explain how certain types of offenders become part of inclusionary versus exclusionary risk policies. Mathiesen (1998) argument however, explains how risk prediction methods are used within actuarial justice, citing that these methods "add an important element of presumed scientific rationality to the incapacitation project as a whole" (1998, 464).

4.1.2. Actuarial Tools

Actuarial justice relies upon actuarial tools. These tools are essential to the classification process. The past few decades have seen a growth in the "sophistication" of the tools used to predict the probability of offender recidivism. Gradually, these tools have replaced clinical judgement and purport to increase efficiency in accurately predicting the probability of offender

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[26] See also Rose (1999) circuits of inclusion and exclusion

[27] According to Mathiesen (1998), "selective incapacitation is the disheartening result and dismal state of collective incapacitation. Rather than across the board incapacitation, the idea is that violent dangerous individuals, or persons who have a certain or high probability of committing violent or dangerous acts, can be identified individually." (1998, 458).

behaviour and recidivism (Bonta and Andrews 2007). These tools categorically discriminate risk levels based on the probabilities of the risk of future reoffending. These risk levels affect select groups of offenders, differently by way of intervention, incapacitation, and/or supervision throughout their sentence.

The past few decades have seen an explosion in the number of actuarial tools used to aid in the process of identification of risk. Actuarial tools ground decisions in statistical relationships, shift decision-making from clinical judgement towards the actuarial model, and rely upon aggregate data to predict the likelihood that a specific "strata" of a population will commit an offence all the way down to individual cases (Silver and Miller 2002). Risk tools are based on the assumption that criminal behaviour of offenders can be reliably predicted, in a "practical and useful manner" (Bonta and Andrews 2007). The Canadian criminal justice system has witnessed a shift towards a reliance on actuarial techniques since the early 1980s.

The tools have also perpetuated a scientific or empirical discourse, a '"common language, a shared knowledge base' when criminologists, psychologists, mental health and justice practitioners discuss 'risk'" (Andrews, Bonta, and Wormith 2006, 9). Therefore, the language of risk is integrated in ways that generate and reinforce a habituated practice of risk management (Horlick-Jones 2005). The discourse of risk, with its claims to *truths,* performs or creates truth by the very act of stating so. Thus, any form of debate related to validity and/or replication of evidence-based research tends to reify the "superiority" of the risk discourse and its claim to *truths*[28] related to risks and the "offender population". Blatantly, Andrew, Bonta, and Wormith(2009) assume this theoretical superiority in their recent analysis of past and future risk assessments: "[t]he general personality and social

[28] For a thorough understanding of this, see Webster and Doob (2004a; 2004b) and Blanchette and Motiuk (2004) on their academic debate surrounding the validity of the Custody Rating Scale used by CSC to conduct their security classifications.

psychology of crime, with special attention to social learning and/or social cognition theory, is now the prominent theoretical position in criminology" (9).

From my professional experience working within the Canadian correctional system, I would argue that one can understand the influence of the realist perspective of risk simply by reviewing a file or offenders' dossiers in which the offender is described and defined exclusively through this risk paradigm. In fact, a recent Canadian Federal Court judgement underscores my point. In *Ewert v. Canada,* 2015 the judge wrote of the impact of actual tools and actuarial scores on how the offender is managed in the Canadian correctional system:

> [58] The evidence establishes that psychologists and CSC rely on the actuarial test scores. The scores matter. The initial scores, as found by O'Mahoney, carried forward through Ewert's term in prison. The score is like a branding – hard to overcome. This is unsurprising, since all types of institutions in society use testing scores that have the tendency to follow the test subject throughout their life in the relevant institution (*Ewert v. Canada* 2015)

4.2. THE GOVERNMENTALITY PERSPECTIVE

The governmentality perspective falls on the opposing end of the "risk" continuum, opposite the realist perspective. As described in the previous chapter, the term governmentality was introduced by Michel Foucault in the 1970s in his exploration of the relation between power, truth/knowledge and governance.

Central to the governmentality framework is the role of technologies and the influence they have on the regulation of the population, body and subjectivity (Dean 1999). In a neo-liberal society, safeguarding the population's welfare becomes the purpose of government (i.e. improvement of the population's health, wealth, and condition). Whereas disciplinary practices were once used to normalize subjects towards uniformity, a shift towards actuarial (risk) practices "seek instead to map out the distribution and arrange strategies to maximize the efficiency of the population as it stands.

Rather than seeking to change people […] an actuarial regime seeks to manage them in place". (Simon 1988, 773).

Generally, there are three kinds of investigations of risk within the governmentality perspective. These various explorative scopes emphasize the complexity and richness of the concept of risk within this particular perspective, they seek to understand: 1) The increase of the deployment of risk techniques across diverse fields; 2) Genealogies of risk, analysts concerned with unanticipated and arbitrary ways that risk based government has come into being or changed direction; and 3) Governmental focus, linking changes in risk techniques with broader political rationalities (O'Malley 2004 11). Despite the various ways of analysing risk within the governmentality perspective, risk is always understood within this perspective as socially constructed, and influenced by power relations as opposed to the realist perspective that emphasizes the objective character of risk and conceptualized by the psychometric paradigm (Lupton 1999).

While most scholars would agree that we have moved towards a risk society, there is much debate as to how risk strategies have evolved (Hannah Moffat 2005) and the diverse configurations in which risk is deployed (O'Malley 2004). Maurutto and Hannah Moffat (2006) in their exploration of risk argued that risk technologies interact and are shaped by institutional agendas, as such, risk as a concept shifts meaning when fused with various rationalities. Their claim is that risk's association with actuarial calculation becomes less accurate as a result of the new assemblages. Moreover, the authors suggest that "as risk technologies are being reinvented and retrofitted, often in unpredictable ways, the concept of risk itself shifts" (439).

Governmentality scholars working in the area of Canadian parole have provided critical insights into the construction of the individual through strategies of neo-liberal governance. Silverstein (2001), for example, traced how parole board members construct the offender (in

conjunction with the offender's family) as someone who should be released on parole versus someone who cannot conform and therefore should remain in prison. In his analysis, Silverstein (2001) illuminated patterns of responsibilization strategies for problematic populations as an influence on that parole board members' decision-making. More recently, Moore and Hannah-Moffat (2005) examined therapeutic discourses and targeted governance practices that construct the offender as free, yet managed through various programs that intend to change or "rehabilitate" offenders (86). Moore and Hannah-Moffat (2005) deconstruct the "punitive turn" thesis to illuminate how seemingly benevolent therapeutic programs control the offender population. Important for my purposes here, these academics highlight how unique Canadian penal practices and patterns in the Canadian surround do not follow a similar trajectory as their geographic partner, the United States.

Garland (1997) argues that neo-liberal society's governance of crime is characterized by an *economic rationality*, which relies on an analytic language of risk that is linked with economic forms of reason and calculations. These *economic rationalities* frame how neoliberal society understands and governs the problem of crime at a macro level[29] (1997, 184). Dean (1999) expands on this theory in his discussion of various forms of *risk rationalities*, some of which are quantitative in nature. *Insurance risk*[30] , which draw on actuarial techniques, and *epidemiological risk* (Dean 1999, 142).

Actuarial risk forms have dominated Canadian correctional policy; actuarial risk assessments such as the SIR, VRAG, and/or the PLC-R[31] are examples of the actuarial *techniques* used by CSC

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[29] Garland also outlines other cost-cutting objectives and audit-like technologies.

[30] Ewald (1991) has characterized risk rationality within discourses and strategies based on the following: calculability (probability of occurring); collective versus individual; and whether the risk or hazard is guaranteed against capital.

[31] For a review of various actuarial risk assessment tools used by Canadian federal correctional professionals, see http://www.johnhoward.ab.ca/pub/C21.htm#actu.

and PBC to conceptualize offenders as risk subjects in an effort to order the offender population according to low, medium, and/or high risk profiles (see Andrews and Bonta 2006; Andrews, Bonta, and Wormith 2006). These profiles are represented by a numerical score to determine probability of recidivism and are used to "anchor" parole board decision-making as "objective" data (Serin 2011).

Dean (1999) explains that within neo-liberal society, governance strategies target "at risk" populations (i.e. populations that threaten the social order) by drawing on information developed through the case-management file. The case management file is then used to identify, target, and manage problem behaviours identified by the assessments and documents located in the dossier. Dean outlines this *case-management risk* as follows:

> Here risk concerns the qualitative assessment of individuals and groups, especially families, as falling within 'at risk' categories. Risk techniques are closely allied to the use of case management in social security, social work, policing, and the sphere of criminal justice. Those judged 'at risk' of being a danger to the wider community are subject to a range of therapeutic (e.g. counselling, self-help groups, support groups, sovereign (prisons, detention centres) and disciplinary (training and re-training) practices in an effort to either eliminate them completely from communal spaces (e.g. by various forms of confinement) or to lower the dangers posed by their risk of alcoholism, drug dependency, sexual diseases, criminal behaviour… (143)

Dean explains that various techniques are used to establish *case-management risk*[32] such as: the interview, bureaucratic or clinical judgement, case files, as well as actuarial instruments in order to assess and document risk factors (144). He argues that through this process, "at risk" subjects can be assessed and managed through various channels and become subject to correction and, if necessary, detainment. Castel (1991) refers to this process as preventative, and argues that the detection of "at risk" populations is a part of a larger process to detect and prevent abnormal and/or deviant behaviour.

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[32] He links *case management risk* with *clinical risk*, a term coined by Weir (1996) to describe how therapeutics are drawn upon through clinical interviews and diagnostics and used as risk assessment.

Responsibilization strategies are a key characteristic of neo-liberal society (Garland 1996; Rose 1996; Moore and Hideyuki 2014). These strategies target individuals by way of enlisting the individuals as active and responsible agents in taking care of themselves (Rose 2000). This is an important strategy used by the crime control industry and provides insight into the ways state agencies govern problem populations, i.e. offenders and/or the "underclass"[33], because these individuals have proven through their choices that they cannot be included as productive citizens within neo-liberal society (Rose 2000). Under this umbrella, citizens are subject to notions of exclusion or inclusion based on their ability to conform to the neo-liberal responsibilized self (Rose 2000, 334).

The notions of choice and responsibility are key assumptions of *responsibilization strategies* (Moore and Hannah-Moffat 2004; Rose 1999; Moore and Hideyuki 2014); the logic that one must assume responsibility for one's actions by making responsible choices in order to be included back into society as responsible citizens.

Risk discourses are a powerful tool for labelling the population and responding to problems because "discourses create "*truth*" by the "establishment of domains in which the practice of true and false can be made at once ordered and pertinent" (Foucault 1991, 79). As such, risk discourses circulating around social control problems order the population in such a manner that an individual's category of risk becomes more necessary *to the question of social control* than treatment or reform of said individuals.

Within a governmentality analysis of risk, the shifting role of the expert, once used to identify and normalize the "pathological", is now used to establish *flows of population*, based on abstract factors that are associated with the notion of "risk". As Castel has argued, "the new

[33] See Simon (1997) for a thorough analysis of the underclass population as it relates to parole.

strategies dissolve the notion of a *subject* or a concrete individual and put in its place a combinatory of *factors*, the factors of risk" (1991, 281). The expert is essential for reinforcing risk knowledges and discourses, and provides strategic "advice" about the population. How these experts define what is risk is subject to interventions by the state and thus, intimately connected with politics (Castel 1991; Horlick-Jones 2005).

According to governmentality theorists, this shift away from managing populations to predicting and managing risk factors has obvious practical implications. For example, Castel (1991) argued that the historical conception of "dangerousness" was used to inform preventative strategies with an aim to identify and contain dangerous individuals[34]. He notes that the concept of risk replaced the notion of dangerousness[35]. This transformation has shifted how society conceptualizes the individual, as a target, a combination of factors that have the probable effect or occurrence of undesirable behaviour. With this shift, we witness a new form of surveillance or a new "space of risk", which includes the creation of an "infinite" number of strategies that target prevention of risk, and the introduction of risk discourses that reinforce potential "risk" factors, as well as identify who are the "at risk" populations (Castel 1991). In other words, these risk profiles are extremely political.

As Lupton (1999) points out, the governmentality perspective "hangs its hat", so to speak, on discourse analysis and does not explore individual resistance to risk. Lupton's (1999) critique of the governmentality perspective does not refer to any specific research that has taken on the task of studying how people respond to risk as part of their everyday life. Yet the body of literature on "messy actualities" and/or "translations" can impart some further insight into the limitations of

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[34] Dangerous in that there were "more or less probable relationship between present symptoms and a certain act to come" (Castel 1991, 283).

[35] According to Castel, "risk in the present day does not arise from the presence of particular precise danger embodied in a concrete individual or group. It is the effect of a combination of abstract factors which render more or less probable the occurrence of undesirable modes of behaviour" (Castel 1991, 287).

relying upon a governmentality perspective to study risk (O'Malley, Weir, and Shearing 1997). For example, theorists have commented on the limitations of the governmentality literature for failing to examine the 'messy actualities' of social relations, resistance or effects by social agents. These critiques extend to the failure to examine the impact of this resistance in the translation of policy to practice (O'Malley, Weir, and Shearing 1997). According to these scholars, risk programmes[36] should be understood only in the process of their implementation and not distinctly in their *analytic* form.

My theoretical toolkit considers this criticism, and intends to contribute to this body of literature by supplementing a governmentality analysis with an examination of how individual parole board members, as agents, engage in the messy job of decision-making. More specifically, I explore how individual parole board members understand file data, are influenced by strategies of control, and how this shapes the outcomes of parole decisions.

4.3. CONCLUSIONS

Parole decisions should be understood in this larger context of neo-liberal governance, a political governance framework that grew out of the demise of the welfare state ideology and which is intricately linked to risk-based logic. In neo-liberalism or post welfare governance, individuals are responsible for their own wellbeing because governance is restructured away from a welfare emphasis, and away from the state. Neo-liberal strategies of governance rely on actuarial data, seen as an extension of positivism that relies on a system of risk assessments and actuarial justice in order to govern populations (Rose 1993).

[36] By programmes I refer to Foucault's definition: "sets of calculated, reasoned prescriptions in terms of which institutions are meant to be reorganized, spaces arranged, behaviors regulated" (Foucault 1991, 80).

As this chapter attests, the focus and/or basic assumptions of risk depend on where on the risk continuum one is positioned. For a realist, this would entail measuring risk as an empirical, knowable object, whereas governmentality theorists understand risk as a socially constructed, neo-liberal strategy in contemporary governance. PBC and CSC situate themselves within the realist perspective, therefore, when I draw on parole decisions and analyze documents produced by these government bodies. I understand that these organizations conceptualize the offender as a knowable risk subject. In order to examine parole decisions, I must engage with the risk literature, namely literature produced from a realist perspective. As a constructionist, my aim is to critically examine how the scientific risk paradigm influences the decision-making process and the role of mental health in the construction of risk.

Chapter 5. Contextualizing Mental Health in the Offender Population

In this chapter, I discuss the concept of mental health as it relates to the offender population. I examine the process of deinstitutionalization and trace its link to the criminalization thesis. I am interested in the trajectory of the deinstitutionalization movement and the professional responses to this movement from the asylum and subsequently in the prison system. I illustrate how institutional actors have constructed the problem of mental health in the offender population as one of over-representation through statistical analysis, namely prevalence rates. In the second part of this chapter, I discuss developments to the psychological screening/intake process within the Canadian correctional system. I link these developments with the advances in the identification of mental health problems among the offender population. I argue that while these "advancements" have provided a better understanding of the extent of mental health problems among the offender population, correctional professional still struggle to respond to the basic mental health needs of offenders. From a critical standpoint, I discuss the effect of diagnostic labels and mental health information in the offender's dossier, potentially constructing the offender as having a mental health "problem". This discussion concludes with a provocative question, does providing decision-makers with diagnostic information detrimental to the release process if the correctional system has not shown a true capacity to treat or rehabilitate this population. I discuss the implications of this on parole decision-making.

5.1. HUMANIZING THE TREATMENT OF SOCIAL VICES

Prior to the 19th century, those deemed mad or disturbed were managed as deviants under the responsibility of their family, usually living as lower class citizens or held within institutions referred to as "madhouses" (Porter 1983). Foucault in particular wrote of the great confinement; an institutionalization movement of confining the mad and other deviant individuals within institutions in Europe throughout the 1600s to the 1800s (Foucault 1965). He explained how the process of institutionalization was justified by a need for public order and protection from problems associated with disorder (Foucault 2006, 344).

For those deemed mentally ill or mad, the asylum and other confinement institutions, such as the reformatory, were utilized as what Foucault and others coin "instruments of social control". The function of these institutions was intended to go beyond the fundamental role of a mental hospital. Public institutions such as mental hospitals were a means to assure the public that custodial care would satisfy an important method of preventing various social ill. For example we can see this in the Quebec legislation of 1909:

> The Loi sur les Asiles d'alienés of 1909:
>
> (4105) Peuvent être admis dans les asiles d'aliénés, aux frais du gouvernement […]
>
> 1.- Les aliénés qui n'ont pas par eux-mêmes, […] les moyens de payer […].
>
> 2.- Les idiots ou imbéciles, lorsqu'ils sont dangereux, une cause de scandale, sujets à des attaques d'épilepsie, ou d'une difformité monstrueuse et sont incapables de payer leur entretien, leur séjour et leur traitement en tout ou en partie; […]
>
> (4115) […] Étant donné qu'un individu est aliéné, son internement peut se justifier, soit comme mesure de thérapeutique, d'assistance ou de sécurité publique et privée et d'ordre public. À part la certitude que l'individu est aliéné, le surintendant médical devra trouver dans le certificat médical, une raison suffisante pour l'interner, à l'un de ces trois points de vue. Ce ne sont pas de vagues présomptions, ce sont des faits que le médecin devra apporter à l'appui de son opinion, lorsque les indications de l'internement ne se déduisent pas exclusivement de la forme particulière d'aliénation mentale dont souffre l'individu.
>
> (Statuts refondus du Québec (R.S.Q.), Ed. VII, 1909, Vol. II, chap. 4, "Lunatic Asylums.")

However, by the middle of the 19th century, these confinement institutions were regarded as inhumane as the public became aware of the conditions within them. Moreover, governments had difficulty sustaining the institutions, which were often overcrowded due to shortfalls[37]. At the same time there was a shift in responsibility and management of those deemed mentally ill. As discussed in Chapter Three, these advancements can be linked to the rise and professionalization of the "psy" knowledges, incorporating a variety of disciplines such as psychology, psychiatry, and/or social work.

"Psy" knowledges rely upon classification tools and observations, and are characterized by claims of objectivity and neutrality and linked with a specialized area of modern medicine, particularly concerned with disease or pathology as is related to the mind. Herein, the role of the practitioner is authoritative; he/she is the expert of the process of diagnosis and treatment of disease. I draw on Rose's description of diagnosis and disease here:

> To diagnose is to discriminate or differentiate […] disease became what the doctor saw in the fabric of the body; disease is to say, became a relation between a form of visualization or symptomatology (a language of description of the visual and tactile, a descriptive, probing, educated empiricism of the medical senses) and a set of procedures for organizing medical statements (the clinical case, the autopsy, the examination, the case history). To diagnose – the verb form emerged in the middle of the nineteenth century - was not to locate an essence, but to establish a singularity or individuation within a whole set of relations by means of a work on symptoms (57).

The notion of mental health as normal or abnormal has been subject to much critical commentary. For example, Canguilhem (1978) questions the plausibility of medical knowledge to scientifically respond to concepts linked with human needs, based on a normative model. In other words, he questions notions of "normal" and if normalcy is the same as being "healthy", further questioning how normativity based on some statistical method can explain the complexity of biological or

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[37] Paradis, "Le sous-financement gouvernemental."

physiological disorders. He also argues that being considered normal, cannot be understood through a scientific lens because clinical assessments are problematic spaces that assess behaviour within an artificial environment. Clarifying further that, the living being and his environment are not normal: "it is their relationship that make them such" (143).

Similarly, Szasz (1960) challenged the notion that mental illness was a brain disease, insisting instead that mental health problems should be thought of as a problem in living. For Szasz, it should not be the role of the doctors to define health but those who experience problems with their health, those are people who are the best assessors of their health. Following a similar trajectory of criticism made by Canguilhem, Szasz maintained that mental symptoms are judgements made by observers to the problems they deem abnormal.

The psy knowledges are intricately linked to the medical model, which contends that mental health problems have biological roots, can be identified and diagnosed through a scientifically informed process[38]. From a medical model perspective, mental disorders are illnesses of the mind (Zachar 2000). However the understanding of the root cause of mental illness has been challenged throughout the 20th century as research has extended hypothetical causes of mental illness beyond their biological roots to social contexts. Consequently, a modern day understanding of the concept of the medical model has emerged[39]. The medical model is currently understood as the process that identifies and treats mental abnormal behaviour irrespective of the ultimate causes. It is based on the

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[38] The Psychometric Approach is another approach to understanding psychiatric categories, as it relies on scientific methodology, namely statistical analysis and identifies the presence or absence of patterns in data; however both systems claim to be anchored in scientific truths, albeit linked through medicine or statistics (Zachar 2000, 177).

[39] Prior to World War 1, mental illness was understood to be organically linked; however social context began to be considered as a contributing factor after observing the mental health problems of the soldiers who returned from war.

notion that scientific practice should direct and guide decisions made by doctors in the treatment and diagnoses of their patients (Shah and Mountain 2007).

The professionalization of the psy disciplines is linked in particular with the growth of diagnosis and classification that intensified throughout the 19th century in response to pressures to legitimize professional standards. One can examine this growth through various factors. First, appearing in its inaugural edition in 1952, the Diagnostic and Statistical Manual of Mental Disorders (DSM) was a key diagnostic classification manual created in an effort to collect data on mental illness for qualified experts within the field, creating a shared diagnostic manual and language. It has been revised numerous times since 1952 and as of this writing the DSM-5 is the most current edition. According to the American Psychiatric Association, the world's largest group representing psychiatrists:

> The *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) is the standard classification of mental disorders by mental health professionals in the United States. It is intended to be applicable in a wide array of contexts and used by clinicians and researchers of many different orientations (e.g., biological, psychodynamic, cognitive, behavioral, interpersonal, family/systems). The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*DSM-5*) is the current edition and has been designed for use across clinical settings (inpatient, outpatient, partial hospital, consultation-liaison, clinic, private practice, and primary care), with community populations. It can be used by a wide range of health and mental health professionals, including psychiatrists and other physicians, psychologists, social workers, nurses, occupational and rehabilitation therapists, and counselors. It is also a necessary tool for collecting and communicating accurate public health statistics. The DSM consists of three major components: the diagnostic classification, the diagnostic criteria sets, and the descriptive text (APA 2013, 20).

The DSM is an example of a classification system that relies on prototypical categories. As Zachar (2000) explains, "patients are diagnosed according to how well they match the criteria set, but no one criterion or group of criteria is necessary and sufficient […] as opposed to classical categories, categories in the prototype model have 'fuzzy boundaries', so it is not always clear who is and who is

not a member of the category" (2000, 169)[40]. Later editions of the DSM have evolved along with progress of the medical model, placing more emphasis on social context[41].

A second factor connected to the professionalization of the psychology discipline relates to the influence of key persons such as Phillipe Pinel (1745-1826) and Dorethea Dix (1802-1887). These mental health pioneers lobbied for raising the professional standards for professionals working with people understood as suffering from mental health problems, particularly in institutions such as the asylum. Pinel is particularly noteworthy for his dedication to articulating moral therapeutic standards within the field of psychiatry. His technique was based on a close examination and classification of symptoms observed in the people living in asylums. His memoir, "Memoir on Madness" (1794), was written using the classic medical model style of observation, assessment, and diagnosis, and is understood as being a precursory text of modern psychiatry. Pinel was also the first to premise that mental disorders could be cured (Weiner 1992)[42]. Dix, on the other hand, is recognized for her life-long dedication to raising awareness of the inhumane conditions within the institutions and the influence she had on political circles for reform.

Third, the use of psychopharmacology (e.g. anti-psychotic medications) beginning in the 1960s has been cited as revolutionary to the professional management of mental health problems. The impact of psychopharmacology is more far reaching than a simple medical response to mental disorders. Generally, it is suggested that the role of psycho pharmaceuticals played a key role in the management of patients within institutions and their subsequent release into the community (Thifault and Perreault 2012).

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[40] See McCleary (1992) regarding the pressures to legitimate professionals working within parole and the use of manuals and classification systems in advancing these goals.

[41] For more information on social context and the medical model, see Engel (1981).

[42] See full translation of Memoir of Madness: Am J Psychiatry. 1992 Jun; 149(6):725-32.

5.2. DEINSTITUTIONALIZATION

I link the process of deinstitutionalization that began in or around the 1960s to the professionalization of the psy disciplines. Deinstitutionalization is a term that describes the progressive closure of institutions such as asylums and other closed institutions (e.g. reformatories and psychiatric hospitals) in favour of community based alternatives (Bachrach 1994, 24; Cohen 1985). The process was heavily influenced by human rights and disability advocates, who raised awareness of the abuse of power in overcrowded mental institutions, as well as the negative effects on inmates through the warehousing of the mentally ill within these total institutions[43]. Reforms are said to have been made possible through the development of the factors described above, namely the professionalization of the psychological field, interests in humane treatment, and advances in psychopharmacology (anti-psychotic medications). However, the movement itself was motivated by measures to improve the standards of treatment with people with mental illness (Rees 1957). As an attempt to understand the true impact of the closures of mental hospitals, scholars have empirically evaluated the deinstutionalization thesis by examining various factors, such as: 1) hospital downsizing; 2) promotion of outpatient/community treatment with regionalized mental health facilities offering low threshold services; 3) strengthening of the legal rights of mentally ill; and 4) improved legal control of psychiatry to reduce coercion (Schanda and Stompe 2009).

During the first phase of deinstitutionalization in Canada (1960s), it is estimated that there was a decrease in the resident populations of Canadian psychiatric hospitals from 47, 633 to 15, 011 (Goering, Waylenki, and Durbin 2000). Despite the best intentions associated with the deinstitutionalization movement, there was a failure to successfully transition people with mental

[43] According to Goffman, a total institution is "a place of residence and work where a large number of like situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life" (11).

health problems to the community. Numerous factors are said to have impacted the transition including but not limited to: fragmented service delivery for the mentally ill, a mental health system which remained institutionally focused rather than community based, a mental health system that was not comprehensive and available to patients upon need; and a system that was underfunded, faced human resource shortages, lacked measures of accountability, and was plagued by stigma[44].

Deinstitutionalization is purported to have had a huge effect on the correctional population (Motiuk and Porporino 1991; Chiles et al 1990)[45]. As a consequence, this effect has become the focus of much public policy debate (Sealey and Whitehead 2004; Parliament of Canada 2004; Morrow, Dagg, Pederson 2008). The Government of Canada has made considerable efforts to study the issue through prevalence rates of incarcerated offenders with mental health problems (Parliament of Canada 2004; Mental Health Commission of Canada 2009). The Correctional Service of Canada have acknowledged these studies, noting the high prevalence rates of offender with mental health problems. In response, they have made a concerted effort to "improve" the capacity of prison officials to identify, manage and/or treat people with mental health problems[46].

Institutional studies support the "over-representation" effect by comparing the prevalence rates of mental health problems within prison populations with those of the non-incarcerated population. For example, in Canada 2.6 million or 10% of the population reported symptoms consistent with mental health disorders (Statistics Canada 2003), and one in five Canadians are noted

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[44] www.parl.gc.ca/Content/SEN/Committee/381/soci/rep/report1/repintnov04vol1part3-e.htm#_ftn364

[45] As common place as the criminalization thesis has been within the mental health community, academics have invoked a lack of data to support such conclusions with regard to the criminalization of the mentally ill (Engel and Silver 2001; Fisher, Packer, Simon, & Smith 2000; Steadman et al 1984; Teplin 1991).

[46] According the CSC's list of six corporate priorities, the Service identified that it would focus on the "[m]ental health needs of offenders addressed through timely assessment, effective management and appropriate intervention, relevant staff training and rigorous oversight". (http://www.csc-scc.gc.ca/about-us/006-0002-eng.shtml)

to suffer from a mental illness[47] in their lifetime (Health Canada 2002). In comparison, according to a regional study of Correctional Service of Canada (CSC), 31.7% of 267 new intakes in federal penitentiaries in British Columbia alone had a current diagnosis of an Axis 1 mental disorder, and 84% had a 1-month or lifetime Axis 1 diagnosis based on the DSM-IV (Brink, Doherty and Boer 2001). CSC has identified an increase of 10% to 21% between 1997/1998 and 2006/2007 in the proportion of offenders using prescribed medication for mental health issues. Prevalence estimates for Fetal Alcohol Spectrum Disorder (FASD) are significant, ranging from 9.8% to 23.3% of the CSC population (OCI 2015). Most recently, CSC has identified that 70% of offenders coming into the system have mental disorders, however this statistic drops to 40% once substance abuse disorders and Antisocial Personality Disorder is removed from the sample (CSC 2013; 2015c). Finally, CSC estimates that 3.5% of the inmate population has acute mental health needs and 6.4% require intermediate intervention care (OCI 2015).

Since 2005, CSC has invested 90 million dollars to support health care. At the time of writing, CSC's total health care budget is documented as $216.7 million dollars, of which 31% is allocated to mental health (OCI 2015). Canada's Correctional Investigator has deconstructed the problem further by explaining the challenges related to the high proportion of offenders in the Federal population in a recent Annual Report (2012-2013):

> Canada's correctional authority continues to face increasing costs and challenges in managing a higher proportion of the offender population with mental health concerns. The most recent data available indicates that the Correctional Service delivered at least one institutional mental health service to 48.3% of the total inmate population, with 47% of Aboriginal offenders and 75% of women offenders receiving services in FY 2011-12. Just over 90% (or 4,065) of newly admitted offenders were comprehensively screened for potential mental health problems last year; nearly two-thirds were flagged for follow-up mental health interventions. The Service also delivered *Fundamentals of Mental Health* training to 2,438 staff in fiscal year 2011-12. (OCI 2013)

[47] In this study, mental illness was measured by the presence of mental disorders as per the DSM.

Across Canada, high rates of mental illness are also being reported in provincial jails. A 1994 study (Arboleda-Florez 1994) conducted in an Alberta remand centre identified a higher prevalence of mental illness within their remand population compared to the general population. This study defined mental illness through clinical interviews using the DSM-III-R (DSM-III-R) and data from legal, criminological and medical records of inmates. In 2008, the Ministry of Community Safety and Correctional Services (MCSCS) in Ontario identified that 15% of their incarcerated population required clinical intervention for mental health problems (Ministry of Ontario 2008). Similarly, based on admissions from 1997-2004, a British Columbia provincial corrections study identified that 26% of the prison population had been medically diagnosed with a mental disorder unrelated to substance abuse. This figure was raised to 30% when substance abuse disorders were included, which represent diagnosable mental health disorders in the DSM-111-R and subsequent editions (Somers, Julian, Cartar, and Russo 2008). Most recently, research has estimated that approximately 41% of offenders in the Ontario provincial system have a current severe symptom of a mental health problem (Brown, Hirdes, and Fries 2013). These studies support the "over representation" argument.

One important organizational variable to explain the increase in correctional prevalence rates of mental health problems can be traced to the advancement of a standardized clinical process to identify offenders upon admission to CSC, who may require a more in-depth mental health assessment[48]. The Computerized Mental Health Intake Screen System (CoMHISS) is CSC's mental

[48] Correctional Service of Canada, "Towards a continuum of care: Correctional Service of Canada Continuum of Care http://www.csc-scc.gc.ca/text/pblct/health/tcc-eng.shtml , Web. March 5, 2015.

health screening process[49] and is comprised of a computer administered psychometric test battery that seeks to objectively measures indicators of mental health including, but not limited to depression, suicidal ideation, anxiety, and obsessive compulsive and psychotic disorders. The assessment process was developed by the Correctional Service of Canada to systematically identify and diagnose mental health problems of prisoners entering the correctional system. According to CSC, "[a]ll federal offenders arriving at a reception centre will be offered the CoMHISS. Since CoMHISS will be implemented system-wide, offenders' identification information (i.e. age, gender) and test scores will automatically be gathered to generate institutional, regional, and national profiles of mental health needs within the CSC environment[50]."

Other Canadian scholars are currently developing a system of screening tools geared at the provincial correctional context. According to this group of researchers:

> The interRAI CF is an assessment system for use in correctional inmate populations. It combines individual items and scales from the interRAI MH and its Forensic Supplement. Designed specifically to be used in jails, correctional centers, and prisons, it measures mental health symptoms and describes the mental health care needs of inmates. The interRAI CF is designed to be used by correctional services professional staff, including psychiatrists, psychologists, nursing staff and social workers.
>
> The interRAI CF was piloted in a state-mandated 2009 study of mental health in the Michigan state prison system. It provides valuable information about the prevalence of symptoms and mental health care for correctional services' planning and policy purposes (InterRAI 2015).

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[49] CSC has developed a mental health strategy, comprised of five components that target the offender through their sentence from arrival to the institution through their eventual release to the community. Each component is framed by various "practices" and "tools", created based on clinical research. The components are as follows: 1) mental health screening at intake; 2) primary mental health care; 3) intermediate mental health care; 4) intensive or acute care; and 5) transitional care for support for release into the community (CSC 2015b).

[50] (http://www.csc-scc.gc.ca/atip/007006-0010-eng.shtml).

Although CSC is getting better at identifying prevalence rates of mental health problems, there is considerable evidence to suggest that the millions of dollars in funding directed to the issue of over-representation of mental health problems among offenders over the past decade has not improved the conditions or quality of care for this population:

> Since 2005, the Service has invested approximately $90M in new funds to strengthen primary institutional mental health care service delivery, implement mental health screening at admission, train front-line staff in mental health awareness and enhance community partnerships and discharge planning for offenders with mental health disorders. These initiatives are part of CSC's five-point mental health strategy. Health care remains the number one category of offender complaint to the Office. Staff visits to CSC facilities across the country confirm that access to health care, particularly mental health services and acute or complex care, remains fragmented and variable, especially in more remote penitentiaries. As I have reported previously, in terms of inmate access to health care that meets professional and community standards of care, the CSC faces important staffing, recruitment and retention challenges. The Service employs a total of approximately 1,200 health care professionals, including nurses, psychologists, pharmacists, medical doctors and social workers. For FY 2011-12, the national vacancy rate for all health care positions in CSC was just over 8.5%. The psychologist vacancy rate in 2011-12 was 16% or 51 positions. The psychologist vacancy rate was highest for the Ontario region, at 29% or 23 positions. Fifty of 329 psychologist positions (or 15%) were filled by incumbents who are non-licensed staff (or "under-fills") and cannot deliver the same level or range of services as licensed psychologists. In other words, nearly one-third of CSC's total psychologist staff complement is either vacant or "under-filled." Complicating professional recruitment and retention efforts are concerns about scope of practice, inter-provincial licensing and accreditation issues, as well as issues related to pay, professional development, and terms and conditions of employment. (OCI 2013)

In other words, even though correctional authorities are better able to identify the mental health problems among offenders, government funding to address the issue has been unsuccessful in attracting and/or retaining qualified staff to work within the prison to treat the offenders[51]. Theoretically, the pressure to fund, train staff, and/or treat the mentally ill in prison does not actually address the concerns raised by the criminalization hypothesis. In fact, it ignores the larger

[51] www.pipsc.ca/portal/page/portal/website/employers/departments/csc/minsept309

failures of the deinstitutionalization movement to integrate the mentally ill into the community and to treat their illness through community based treatment programs.

5.3. REFRAMING THE NARRATIVE

CSC has improved its screening process in an effort to understand the extent of mental health problems in offenders within the prison system. Based on the statistical studies that confirm a high proportion of offenders in the prison system, CSC has acknowledged and prioritized its commitment to addressing the mental health needs of those offenders. However, there is a documented lack of adequate resources to address those needs. I admit that screening practices in Canadian corrections have had significant implications in the advancement or in the production of knowledge about the offender population in relation to mental health. In fact, screening processes such as the CoMHISS at the federal level, and interRAI at the provincial level, are effects of the production of psy knowledge. In other words, these intake and assessment processes produce clinical or expert knowledge about the offender's mental health, which the institution can then draw upon in the construction of the offender. Since the assessment process involves a battery of tests to understand the offender's current mental health and past problems with mental health, the new process produces a specialized and clinical dimension of information for correctional authorities to 'know' the offender. This knowledge is then analyzed and a psychological profile is generated about the offender and placed on his/her dossier.

My questions are these: does this mental health-related information make its way into case management files? If so, what influence does this diagnostic information have on the process of decision-making, especially as it relates to parole? As described by Pearlin (1999, 410), "[s]ociological interest in mental health and disorder is rooted in its mission to identify elements of social life that have dysfunctional consequences". Broadly speaking, critical scholarship in this area

examines how the displacement of problematic persons with mental illness to the prison setting acts as a viable social control option (Christie 1993; Cohen 1985). If the DSM has a functional role as an empirical tool in the classification, diagnosis, and treatment of mental disorders, it also has significant consequences on social structures and relationships. Therefore, the classification system of the DSM assumes an important social function in the control of vulnerable populations by providing: 1) legitimization or reproduction of psy knowledges; and 2) creation of truths of subjects as deviant, abnormal, disordered; and 3) diagnostic power that merged with risk logics to inform decisions within control institutions such as the criminal justice system (Christie 1993; Cohen 1985; Rose 1999; Foucault).

From this critical standpoint, I argue that the advancements in screening for mental health, although a benevolent endeavour to assess and identify offenders' needs in order to then treat these problems, could have adverse effects for the offender population. This is based on the logic that mental health is used in the construction of the offender in the parole release decision. Based on the few extant studies, referenced in the introduction of this research, it would seem that information about mental health is used. But how it is understood and drawn upon by decision-makers is relatively unknown. This research seeks to fill that gap in the research. One of the goals of this research is to shed light on the effects of the practices related to an offender's mental health. The implications could be significant, especially when we consider the criticism raised by Government of Canada agencies, such as the Office of the Correctional Investigator, that argue that CSC does not have the capacity to adequately meet the needs of offenders with mental health problems. Does knowledge of the offender's mental health add a new dimension to the decision-making process? This dissertation provides an opportunity to examine this concern.

5.4. CONCLUSIONS

In this chapter, I have examined the process of deinstitutionalization and its link to the criminalization thesis. In particular, I traced the trajectory of the deinstitutionalization movement and the professional responses to this movement related to the treatment of the mentally ill in the asylum and subsequent indirect transition to the prison system. I illustrate how scholars and government agencies have constructed problems of "over-representation" through statistical analysis, namely prevalence rates. I drew attention to unforseen consequences of this process by highlighting a possible conundrum: CSC is better than it was at screening for the presence of mental health problems but has yet a limited capacity to meet the needs of the offender population. What, if any, impact does this have on the offender's dossier and decision-making related to the offender with mental health problems?

Chapter 6. Methodology

The following section will outline my methodological approach to this study. Here I review my chosen methods and data collection procedures. I comment on insider and outsider standpoints and then review my coding techniques. I discuss both first cycle and second cycle coding to provide the reader with a clear understanding of the manner in which I coded my data.

6.1. RESEARCH METHODS

I employed an applied qualitative research approach. This type of research is often undertaken to inform policy, usually within government, staying true to the actors' understandings and the settings of the particular area of study (Walker 1985). As explained by Walker (1985), applied qualitative analysis is well suited for areas of study that are not well defined and/or are highly complex, thus ruling out the ability to grasp the nuances of a phenomenon through the use of statistical analysis (i.e. surveys) alone. Richie and Spence (2002) further explain that applied qualitative research is different from theoretical qualitative research in its expectation or "potential for actionable outcomes" (2002, 306). In other words, applied research can be a useful tool in the examination of social policies in pragmatic ways such as, but not limited to improving, illuminating, or simply providing a better understanding of how the policy is being articulated and implemented at the organizational level. Given the complexity of the decision-making process, specifically the intimate linkage between PBC and the larger criminal justice political agenda, I believe that this type of analysis is required to begin exploration into how parole board members understand, operationalise and reference mental health in their decision-making process.

6.2. DATA COLLECTION METHODS

For my data collection, I used a data triangulation method (i.e. using more than one approach to data collection) in order to corroborate and strengthen my analysis (Eisenhardt 2002; De Vos, Delport, Fouche and Styrdom 2002). By collecting data through more than one source, I was able to achieve a better understanding of the data through the illumination of multiple dimensions and/or perspectives. This is especially the case in this project where the object of analysis, mental health problems within a parole decision-making process is such a vague construct, despite the existence of the DSM diagnostic manual. I made every effort to explore all sources available to me to gain a more comprehensive understanding of mental health problems and parole decisions. The following methods of data collection were used in this study:

1. Public documents (i.e. PBC mission statements, policy handbooks, training manuals, and/or annual reports, legal documents and research, reports of government such as the Correctional Law Project, Commissions, Inquiries and/or law documents)
2. Interviews with former parole board members
3. Participant observation of parole board hearings
4. Records of parole decisions.

I conducted four interviews with former parole board members, I observed 17 parole board hearings at various institutional security levels over eight business days, and reviewed 48 decisions for day and full parole (DP/FP), and detention reviews within the PBC decision registry. I was also able to conduct informal discussions with parole board members at the end of each day that I observed 17 parole hearings. These were useful conversations to go over any questions I had with regard to the process I had observed during that day. The following sections discuss in greater detail the four above noted methods of data collection.

6.2.1. Public Documents

I reviewed official documents produced by the Canadian federal government body, which included PBC mission statements, PBC and CSC policy handbooks, PBC parole board training manuals, and/or government annual reports. Also in this category, I reviewed legal documents and research produced for consumption by the public, such as the government reports (i.e. the Correctional Law Project), Commissions, Inquiries and/or law documents as they relate to correctional operations. These documents acted as sources of data to assess how the PBC frames the concept of mental health, or at least, how mental health has come to be understood as a construct within the organization. Most of these relevant documents were reviewed in the risk, parole, and mental health chapters.

6.2.2. Interviews with Former Parole Board Members

As aptly described by Mopas and Turnbull (2011), gaining access to government institutions remains a difficult hurdle to overcome within the research process, particularly with regard to research in criminology that seeks to examine processes and institutions that may be vulnerable to external critical research (2011, 586). Negative research could create a perceived threat to the government's ability to administer the care and custody of the offender population, and this in turn, could threaten the integrity of the institution. In order to be efficient in my research aims, I was required to create realistic boundaries and consider this obstacle for my research plan (DeCuir-Gunby, Marshall, and McCulloch 2011; Miles and Huberman 1994).

Throughout my doctoral studies I observed the difficulty other students had gaining access to CSC or PBC data. Based on these observed hurdles and delays in their projects I chose not to seek permission from PBC to access and interview parole board members as I expected that the request would be denied. This decision could be viewed as a bias but I would argue that I took a practical

approach in my research planning. My original snowball recruitment sample plan involved approaching a former parole board member and requesting an interview and subsequently, initiating a chain method recruitment sample whereby the participant or informant recruited other potential participants and referred them to contact me should they be interested in participating in the study. I required REB approval for this form of data collection[52]. I had difficulty with this recruitment process and after three months of not receiving any referrals, I decided that I had to modify my recruitment sample. This is understood as an adjustment to my data collection plan during the research project and should not be confused with a less rigorous/systematic process of data collection (Eisenhardt 2002, 16-17).

I have worked within the field of federal corrections for close to fifteen years. During that time, I have met and interacted with many parole board members and/or had common colleagues refer these people as possible participants. Over the years I have also come to know many people who had at one time worked as a parole board member. I contacted one of these people through their social media sites, LinkedIn, which is an online professional networking tool. I introduced myself through the recruitment letter and invited them to be part of the study. Also, I accessed emails in the public domain and introduced myself to other parole board members via the recruitment letter.

At the time of recruitment, three out of the four former parole board members that I interviewed for my dissertation were not aware that I was a criminal justice bureaucrat, as well as a

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[52] Approval for this project was obtained from the Research and Ethics Board (REB) at the University of Ottawa [Appendix A]. A request for modification was approved shortly thereafter for my participant sample and my participant recruitment process as I was unable to secure potential participants through the method approved in the original proposal. Namely, I had originally relied on my participant sample to pass on my name and contact information to former parole board members. The modified process permitted me to contact former board members directly through various recruitment processes

doctoral student. All participants were informed during the interview process of my dual status. The decision to inform the members was conscious and will be discussed further in this chapter.

I conducted a total of four semi-structured interviews [Appendix B]. One was conducted in person; and three others were conducted over the telephone as geography did not permit me to interview them in person. Consent was obtained prior to the scheduling of the interview. In all cases, I sent the recruitment letter to the participant [Appendix C]. I received a signed consent form via fax or email for all interviews scheduled over the phone. The interviews were audio recorded and transcribed. The transcriptions were sent to the participants within the week for review. Participants were encouraged to add, change, and/or delete any information they felt did not represent what they intended to convey. This exchange was intended to allow for the participant to actively reflect on how they constructed the meaning they attributed to the concepts and questions that I raised in the interview and provide a forum to represent accurately their perspective. This process of review is epistemologically rooted in the constructionist understanding that the participant comes to the interview with the experience and facts necessary to respond to the subject matter. However, it is through the interview process that the participants actively and subjectively construct the detail (Holstein and Gubrium 1997, 117; Silverman 2006, 114). Therefore, reviewing the documents with an aim to add or delete and information is not detrimental to the study. Accordingly, and consistent with this model, it is more important to capture how the participants understood the concept of mental health after reflection rather than using only their initial response to the questions as a "true" account of their opinion on the subject (Silverman 2006).

The interviews were conducted following my observation of the 17 hearings. During the observation of the hearings, I began to notice that the larger theme of psychopathy seemed to be a noteworthy concept to consider as this term was often brought up in the hearings as a meta-label of the offender and I believed that it was worthwhile to investigate this term further to examine its link

with a parole board member's understanding of mental health. Therefore, I used the interview as an opportunity to engage my burgeoning thoughts on this theme even though it was not identified in the interview script (Rapley 2004, 27). I note that only one of the participants brought up the concept naturally in the interview. However, for the remaining three participants, I prompted them to discuss their understanding of the topic with me. By prompting the participants to discuss how they understood the term psychopathy, the interview allowed me to further dissect this concept for analysis later on in the research stages.

6.2.3. Observation of Parole Board Hearings

As previously discussed the hearing is an administrative process whereby the board interviews the offender. Hearings are formal but perhaps not as formal as the actual record of decision that follows each parole decision, which is the written record of the parole board member's reasons for the decision. As Hannah-Moffat and Yule (2011) note, although the record of decision may not reveal the true insight for the parole board members' decision-making process, the documents are useful in that they allow the researcher information about aspects of the offender's file that the decision-maker draws upon in the determination of suitability in the release decision. During the parole board hearing process parole board members can draw on any information in the file to discuss with the offender. I anticipated observing and collecting data in a manner that was not necessarily defined through a pre-assigned thematic or structural format. Overall, it was through this opportunity for observation that I was able to immerse myself into the setting and observe how parole board members, assistants, and the offenders articulated or responded to issues and concepts associated with mental health, often spontaneously, without the process being entirely scripted.

Parole Board of Canada hearings are open to the public. The only requirement to attend these hearings is to register in advance in order to obtain approval to be a visitor to the hearing. During

the hearings, I was not permitted to interact in the process and my presence was permitted vis-a-vis my status as a public citizen. REB review is not required for research involving the observation of people in public places where individuals or groups selected for observation have no reasonable expectation of privacy. Therefore, I did not seek ethics approval for this source of data collection however REB did note that I should be prepared to respond to questions regarding my presence at these hearings. This proved to be useful advice as each day at the hearings I was asked who I was and what was my research.

In order to attend parole hearings, I was required to complete a Request to Observe a Hearing application. My status as a public servant within the criminal justice field was known to most, if not all, PBC employees that I interacted with. My decision to identify myself to the PBC in the application process to be an observer to the hearings was a conscious decision. As a public servant in the Public Safety Government of Canada portfolio, I cannot be or seen to be in a conflict of interest at the institutions where I was observing hearings. This is especially the case in the Ontario region where I am known as an employee of the Office of the Correctional Investigator (OCI)[53]. As the PBC is outside of the OCI's jurisdiction it was not a conflict for me to study the organization. However, since the offenders I was observing and the institutions I was visiting were under the jurisdiction of the OCI, I made every effort to ensure that CSC and PBC were aware that I was visiting institutions as a student researcher and not as investigative staff with OCI. I contacted the warden at each institution I was attending in order to facilitate this transparency with CSC and I identified the days I would be on site and as well, explained that I would be attending the institution as a student of the University of Ottawa. I was required to leave all my belongings in my car and use

[53] As the ombudsman for federally sentenced offenders, the Office of the Correctional Investigator serves Canadians and contributes to safe, lawful and humane corrections through independent oversight of the Correctional Service of Canada by providing accessible, impartial and timely investigation of individual and systemic concerns. (http://www.oci-bec.gc.ca/index-eng.aspx)

my personal identification as all other public visitors to institutions do when they visit a federal institution.

When the board members did not know my status as an employee of OCI, I often heard the hearing officer inform the parole board member that I worked at the OCI. I am not sure of the reason for this however I will offer my thoughts of why this may have occurred later in this chapter. Before and during hearings PBC parole board members approached me. I even had parole board members approach me in the parking lots after the hearings. The board members asked me various questions, mostly centred on my research. I consistently informed all PBC employees that my research was on the general parole decision-making process. I made a conscious decision not to disclose that my specific focus was on mental health as I did not want the members to inadvertently discuss this variable within the hearing. However, at the end of each day that I observed hearings I mentioned that I was interested in the concept of mental health within the decision-making process. As there were different parole board members assigned daily to the hearings, I note that there were two days when the same parole board members were assigned to hearings I had already observed. Therefore, I assumed that on these days the board members were aware that I was interested in mental health in the parole board decision-making process.

I observed 17 parole board hearings at various male institutions of various security levels over eight business days[54]. I chose the Ontario region due to the proximity of the hearings to my home. Table 4 details the type of conditional release, what level of security and the outcome of each of the 17 hearings.

[54] I work closely with the female offender population through my role at OCI so studying this population was not ideal as I would likely be able to identify the women and vice versa. Therefore, the potential for bias was significant.

PBM	Gender of PBM	Career prior to being a PBM	Type of Release	Institution	Security L	Offender Race	Decision or Outcome	Legal Assistant
Hearing 1	Male	Addictions	DP	Bath	Medium	Caucasion	Deny	yes
Hearing 1	Male	Police	DP	Bath	Medium	Caucasion	Deny	yes
Hearing 2	Male	Addictions	DP	Bath	Medium	Caucasion	Grant	no
Hearing 2	Male	Police	DP	Bath	Medium	Caucasion	Grant	no
Hearing 3	Male	Addictions	DP	Bath	Medium	Black	Deny	no
Hearing 3	Male	Police	DP	Bath	Medium	Black	Deny	no
Hearing 4	Male	Police	DP	Joyceville	Minimum	Caucasion	Deny	no
Hearing 4	Female	Finance	DP	Joyceville	Minimum	Caucasion	Deny	no
Hearing 5	Male	Police	FP	Joyceville	Minimum	Caucasion	Deny	yes
Hearing 5	Female	Finance	FP	Joyceville	Minimum	Caucasion	Deny	yes
Hearing 6	Male	Police	DP	Joyceville	Minimum	Black	Grant	yes
Hearing 6	Female	Finance	DP	Joyceville	Minimum	Black	Grant	yes
Hearing 7	Male	Police	DP	Joyceville	Minimum	Arabic	Grant	yes
Hearing 7	Female	Finance	DP	Joyceville	Minimum	Arabic	Grant	yes
Hearing 8	Male	Police	UTA	Joyceville	Minimum	Caucasion	Deny	yes
Hearing 8	Female	Finance	UTA	Joyceville	Minimum	Caucasion	Deny	yes
Hearing 9	Male	Public Policy	UTA	Joyceville	Minimum	Caucasion	Deny	yes
Hearing 9	Male	Lawyer	UTA	Joyceville	Minimum	Caucasion	Deny	yes
Hearing 10	Male	Public Policy	DP	Joyceville	Minimum	Caucasion	Grant	no
Hearing 10	Male	Lawyer	DP	Joyceville	Minimum	Caucasion	Grant	no
Hearing 11	Male	Public Policy	DP	Joyceville	Minimum	Caucasion	Grant	no
Hearing 11	Male	Lawyer	DP	Joyceville	Minimum	Caucasion	Grant	no
Hearing 12	Female	Finance	DP	Joyceville	Minimum	Caucasion	Grant	no
Hearing 12	Male	Police	DP	Joyceville	Minimum	Caucasion	Grant	no
Hearing 13	Female	Finance	DP	Joyceville	Minimum	Caucasion	Grant	yes
Hearing 13	Male	Police	DP	Joyceville	Minimum	Caucasion	Grant	yes
Hearing 14	Female	Finance	DP	Joyceville	Minimum	Black	Grant	no
Hearing 14	Male	Finance	DP	Joyceville	Minimum	Black	Grant	no
Hearing 15	Female	Finance	FP	Millhaven	Maximum	Arabic	Deny	no
Hearing 15	Male	Public Policy	FP	Millhaven	Maximum	Arabic	Deny	no
Hearing 16	Male	Public Policy	DR	Millhaven	Maximum	Black	Deny	yes
Hearing 16	Female	Public Policy	DR	Millhaven	Maximum	Black	Deny	yes
Hearing 17	Male	Police	FP	Millhaven	Maximum	Caucasion	Deny	yes
Hearing 17	Male	Police	FP	Millhaven	Maximum	Caucasion	Deny	yes

Table 4 - Attribute Data in Hearing Sample

According to this categorization of the parole board members' attributes, I was able to note a few potential influences on my data set. First, there were only two women parole board members in the seventeen hearings. Based on this board composition, there were too few women to analyze gender and link with broader themes of any significance. Moreover, there was a strong policing background noted in the Ontario region board composition, I will speak to this possible influence on the decision-making process in Chapter Seven: Discussion of Findings.

All hearings began at 8:30am in the Kingston, Ontario region. There were usually no pauses between the hearings as the board members conducted hearings back to back. Therefore, I was usually at the institution for approximately 4-6 hours. In total, I completed no less than 32 hours at the various institutions. However I estimate the total number of hours was closer to 50 due to all the extra conversations I engaged in with staff, offenders and observers before and after the hearings. Two board members were responsible for conducting a hearing each day. Different board members were assigned to the various hearings and the board members remained for the duration of the day. In a few instances there were board members in training who sat in to observe the hearings but did not participate in the deliberations. There is a hearing officer assigned to each hearing who facilitates the process such as stating the rights of the offender at the commencement of the hearing and coordinating how the offender, observers, and assistant are brought into the room. The parole board members were not involved with any of this process. The rooms were structured by the offender and the board members sitting directly opposite to one another, either across a table by organizing two long tables parallel to one another, similar to a court room with the judge looking at the accused. If there was an assistant present, the assistant sat directly beside the offender. Observers, including victims sat off to the side of the room but usually directly behind the offender.

Participant Observation

My observation of the parole board hearings corresponds to what is termed "ethnographic participant observation". According to Delamont (2004), "Participant observation, ethnography and fieldwork are all used interchangeably […] they can mean spending long periods of time watching people, coupled with talking to them about what they are doing, thinking and saying, with the objective of seeing how they understand their world" (218). In particular, I wanted to study the phenomenon based on a commitment to how the institution actually worked. Here, I am drawing on Smith's (1987) conceptualization of an institutional ethnography, in which institutions and institutional texts play an important role in the technologies of social control:

> Institutional and Institution identify a complex of relations forming part of the ruling apparatus, organized around a distinctive function – education, health care, law, and the like. In contrast to such concepts as bureaucracy, "institution" does not identify a determinate form of social organization, but rather the intersection and coordination of more than one relational mode of the ruling apparatus (Smith 1987, 160)

Therefore, the process of observing spontaneous conversations within the hearing between the parole board member and the offender, within their working context was understood as an invaluable method to understand dynamics that could not be observed or analyzed vis a vis a document analysis or statistical inquiry (Watt-Jones 2010). This opportunity also addressed the identified gap in the literature as noted by other academics who have studied parole decisions and mental health, namely that observing the hearings could produce a more robust understanding of how parole decision makers themselves operationalize mental health (Feder 2004; Matejkowski 2011).

Insider versus Outsider Researcher

As part of the investigative process of research it is important that I situate myself within this project as both the primary researcher and as a bureaucrat within the Canadian federal public service in the correctional field. During my 13-year career in the public service, 10 were spent working on

the front line of federal corrections. First as a community federal parole officer and second, as a manager with the Office of the Correctional Investigator, an ombuds agency responsible for reviewing and resolving complaints by federal offenders against the Correctional Service of Canada. These positions have afforded me particular insight and access into the inner workings of the parole board hearing. In particular, my work roles educated me on how to navigate and understand the parole board hearing and decision process in its entirety, both as a participant while a parole officer and as a reviewer of the decisions as an actor within the system.

It is with this level of insight that I also endeavoured to commit myself to an ongoing process of reflexivity. As Berg (2009) explains, "to accomplish this, the researcher must make use of an internal dialogue that repeatedly examines what the researcher knows and how the researcher came to know this" (198). As noted above, I made a conscious decision to inform PBC as an organization that I was also a criminal justice "actor" due to being a public servant. The primary reason for this decision was that I did not want to inadvertently be in a position of conflict of interest with regard to my professional work as a result of my status as a researcher. However, another important reason was that I did not want the participants to feel as though I was not being forthcoming with regard to my insider research status. On the contrary, I wanted to use my experience within the correctional system to encourage a sense of trust between the researcher and the participant.

Numerous researchers have discussed the advantages of being an insider in the research process (Mullings 1999; Dobson 2009; Brannick and Coghlan 2006). Perhaps the most obvious is that by identifying myself as an insider I was actively *framing* the shared experiences I may (or may not) share with participants who also worked in the Canadian correctional system. Therefore, my identification with the participants could foster a sense of trust or understanding between myself and the participants. This of course led to unplanned issues that I had to reconcile during the research process. For example, given my dual role that granted me what appeared to be immediate access, I

had to actively concentrate on the surroundings within which the hearings took place, or how the offender was managed during a process that was, of course, already familiar to me. Furthermore, I found myself in conversations that I was unsure if I could use as data for fear it was told to me in confidence as an actor in the system, rather than as a researcher. This occurred during one instance when a parole board member came into the waiting room during a break between clients to ask about my thoughts regarding the hearing that day. Adler and Adler (1987) refer to this as the "ultimate existential dual role", whereby I found myself in a position in which I had to record data as part of my ethnographic notes but I was aware that by writing this it could compromise the integrity of the hearing process. In order to resolve the issue, I simply restated back to parole board member what I interpreted during the hearing. On two other occasions while observing hearings, I reminded parole board members that I was a researcher and was actively recording data. During one interview (not the hearings), given a work relationship I had with the participant, I was careful to not stray too far from the structure of the interview guide in order to remain as objective as I could during the interview process.

Finally, I kept a reflexivity journal throughout the process of field work, during my coding, and throughout the analysis. This process allowed me to write down thoughts, biases, and tensions to which I was subject throughout the research process. For example, my journal entries identify the tension I felt related to my presences in the back stage of the hearings while waiting for the "actual" hearing to begin. It is through these observations and notes that I was able to later analyze actors and power as detailed in Chapter Eight.

In the end, however, I would argue that my insider status had benefits to this research; the experiences I brought to the research permitted me to focus on the process much more precisely without being overwhelmed by the language within the hearings related to correctional process. For example, I was able to quickly understand the technical jargon related to correctional planning used

in the hearing process (or other data sources). I was also familiar and comfortable with the larger prison environment, which can be intimidating to outsiders who are not used to such a controlling or structured environment. For example, when registering myself at the front of Joyceville minimum institution as a researcher, the officer was quite rude to me and other visitors by demanding that we wait in one single line. She initially denied my entrance as PBC did not record me as a visitor in the CSC facility for the hearings for the day. When I provided my letter of acceptance, this seemed to aggravate her further and she reminded me that she, representing CSC, would decide on the matter. I could not help to reflect the tensions at play and compare the differential treatment I am afforded as a manager with the OCI with how I was being treated as a student researcher. I was also self-aware that I was not intimidated by this tension as I was familiar with prison-visitor dynamics. However, I was also acutely sensitive to the fact that if I disrupted the process at all, this actor in the system could suspend my privilege to observe the hearings. Even if the poor treatment I was receiving from this officer was not fair, I could not afford to lose a day of field research. Therefore, I remained quiet while the officer allowed me to be processed as a visitor on her terms.

Overall, I would emphasize that my insider/outsider status was an important factor in influencing interactions and dynamics involved in my research. Although at times many people I interacted with knew of my insider status, many did not (for example the officer processing my visitor status as discussed above). Knowing the benefits and disadvantages of navigating this process as an insider and/or an outsider to the process and navigating through this process added a different perspective to this research (Dwyer and Buckle 2009). As noted throughout this project, I attempted to be actively reflective in overcoming bias when I could have easily manipulated the process to gain raw data (i.e. through my informal discussions with the parole board members at the end of the day). While reflexivity cannot eliminate all bias, it was essential to the integrity of the research that I acknowledge the position I found myself in while conducting this study.

Ethnographic Note-taking

Prior to observing the hearings, I immersed myself in various documents, articles and books related to how to take and write ethnographic field notes. I consistently drew from the work of Emerson, Fretz, and Shaw's (1995) book on writing ethnographic field notes. Consistent with their work, I recognized the complexity of dialogue and the nuances that I should pay attention to while conducting my field research (75). The attention to detail used to describe the actual parole hearing physical environment (i.e., how the hearing rooms were set up, the roles of the offender, parole board member, observers, and hearing officers) was the result of my field notes and was the data used in dramaturgical coding. In my notes I tried to grasp best how to establish how the hearing process unfolded within the hearings in order to later analyze the importance of the setting. As well, I wanted to ensure that my notes reinforced my credibility that I was attentive to these details of the field (Emerson, Fretz, and Shaw 1995, 201).

I took notes that were later transcribed and coded for meaning of themes, based on latent or manifest data. I also created Excel spreadsheets to examine attribute data related to the hearings. For example, I categorized data based upon the type of conditional release, the security level of the institution, the index offence, and the outcome of the decision for each hearing.

My notes were not just a running record of the conversation between the parole board and the offender. They were also a running record of my observations of how I observed the dynamics of the hearings. When mental health was not an obvious subject, I often wrote down a phrase related to the content in order to fill in details of the hearing. For example, when the discussion was focused on employment plans for release my notes would state discussion on employment plans. As the hearings progressed, my notes also contained behavioural tensions I observed in the hearing. I began to notice that one female board member had certain facial expressions or would speak over an offender when she appeared to be interacting with offenders she believed were misleading her. In

another example, a parole board member who was a lawyer by trade scowled at the offender during his discussion with an offender who was incarcerated for embezzling money from people's retirement fund. I noted these types of contextual details in the margin of my notepad as I made the connection [Appendix D]. I also noted when the offender became upset, and opportunities that could illuminate how the board members responded to this. Consistent with my research questions, I wrote down all factual details that were brought up when certain terms such as psychologist, mental health, a diagnosis, suicide, and/or psychiatric assessment surfaced in the hearing as it was believed these terms were directly related to my research questions.

The following section is a review of notes I took during my field work that describe the hearing process at the various institutional levels. These notes were later transcribed into memos, uploaded to NVIVO and coded for themes and patterns.

Minimum Security

I attended 11 hearings over 5 days at Joyceville minimum security institution. I would always wait before the hearing and during deliberations in the same room with the offender and his supports (i.e. his assistant or lawyer) and any other observers present in the hearing, such as his family. In Goffman's (1959) book, The Presentation of Self in Everyday Life, he makes the argument that human interactions can be understood through the metaphor of the theatre. For him, individuals manage their identity and the impressions of them through their interactions with others. These interactions are understood as performances. Important for the analysis here, according to Goffman there are differences between frontstage and backstage performances. Frontstage performances are understood as the stage wherein actors perform their roles in front of the other actors and audience. The process is orchestrated, with an audience, and the actors work using impression management to present their ideal self. On the other hand, the backstage is understood

as the space where an individual can be most authentic in the absence of an audience. Although the waiting room where I found myself sitting with the offender and their families was not frontstage as it was constructed through the hearing with the parole board members. I did analyze the waiting room interactions as frontstage performances as I was an observer along with other actors who interact with the offender.

There was always a parole officer with the offender in the waiting room, and their interaction was also a constructed through their performances with one another. On one occasion, there were victims in attendance as well. However, the victims were accommodated in another room adjacent to the room we were waiting in. There were no correctional officers present for these hearings aside from the hearing when there was a victim present. The offenders often asked me questions about my research. I provided very basic information about my research stating that I was interested in how parole board members made decisions.

I cannot overestimate the curiosity my presence provoked. I was an obvious outsider to this process, particularly to parole officers and family members of the offender who were there as support to the offender. My presence served to remind the participants that they were being observed. On a few occasions it is the offender that informed their assistant, or parole officer, and/or the family members that I was a student as the offender was provided formal documentation of all persons in attendance at the hearings a few days prior to the hearing vis a vis a formal letter by the PBC. Before the hearing and during deliberations there was not one case in which the offender appeared confident, rather, the offender always appeared nervous, withdrawn, and at times paced the waiting area. Every assistant that accompanied the offender approached me either during the break or after the hearing to ask me about my research. They often provided insightful information regarding their impression of mental health and parole decisions.

I felt at times that I was intruding on the offenders' space during the waiting room before and after the hearings. Goffman (1959) refers to the difficulty in maintaining front stage performances, as it becomes tiring for the actor. In an effort to minimize my own discomfort, I wanted to say a few words of encouragement to aid in the process but I did not interfere and I only responded to questions if they were posed. Examples of questions include what degree I am working towards or what was my research interest. Again, I communicated that the general interest was in the process of how the parole board members make decisions. During deliberations of one hearing I observed the tension between an offender and his parole officer. They were having a disagreement regarding remarks the parole officer said during the hearing. I note that the parole officer was acutely aware of my presence when she was responding or reprimanding the offender, often glancing up to me. I know based on her question later on that day that she was unsure as to who I was. I wonder to myself how she would have responded or interacted with the offender without me being present. For example, would she bring up this disagreement as a factor for the decision makers to know in the hearing as she brought up other examples in the hearing of him being argumentative? Does my presence have any influence on her decision whether or not to bring up their quarrel to the parole board members? In the end, she did not bring up the information in the hearing but the question percolated as to whether or not my presence influenced her decision.

The same offender asked me later the same day if "I enjoyed the show" while we were walking down the hall of the institution following his hearing. I interpret his sarcasm as a response to his annoyance of having to be on frontstage both in the hearing and in the waiting room, for both of which I was an observer. I wonder to myself if his comment was a means of hiding his possible shame. I ruminated all day as to how I wish I could have said something to not make him feel like as though I was watching the show for amusement. I have come to understand, however, that it does not matter why I was watching his hearing or how I could have responded to his remark; he is still

caught up in a system that constantly judges and examines him, and he must be in role constantly managing the impression other have of him as an offender. I am simply one more actor in that web.

The hearings were usually an hour or longer in duration. The room in which the hearings were conducted was quite hot. The days were very long and I spent my time alone with few interactions during the pauses. During one hearing, one of the board members in training fell asleep for approximately twenty minutes. There were also occasions when the offender or his family was so distraught that I found myself having to concentrate not to get emotional. This often occurred when an offender discussed his family or children. Similarly, it was not unusual for me to empathize with offenders when they were happy that they were granted parole. Conversely, I could not help sympathize with an offender's desperation when he begged the board to let him out because he was so old that he "did not want to die in here".

Medium Security

I attended three hearings in one day in the medium security prison. In this setting, the offender was brought to the hearing by a correctional officer. The officer stayed with the offender during the hearing and while the parole board members deliberated. I did not spend any time alone with family or offenders at the medium security institution. Instead, I was assigned to a room down the hall from the hearing. During the breaks of the day one board member approached me to discuss my research interest and my professional job.

Maximum Security

I observed three hearings in two days at Millhaven. At the time of these hearings, Millhaven was the only maximum security prison in the Ontario region. Since the time of my fieldwork CSC restructured the institutions. There are currently three maximum security institutions in the Ontario region. In the maximum security prison the process was very structured as the offender was brought

to the hearing by two correctional officers. While awaiting the hearing I was housed in one locked room, and the offender was in another locked room with his assistant and a correctional officer. One case was a high profile case so there were journalists with me in the waiting area. I recognized one of the three cases presented at this institution as one of the 25 detention files I received as part of the parole registry. This was flagged for further review.

Millhaven Institution maximum security staff were very familiar with me as an employee of OCI. In fact, upon arrival to the institution I was removed from a line of various observers to be sniffed by drug dogs as per policy to enter the institution. I was advised by the CSC manager on duty that they felt it was inappropriate for me as an employee of OCI to be searched. I agreed to this as I did not want to further disrupt the process. I also had to remove myself from one hearing at Millhaven as the offender was a previous client I had worked with in my role with OCI and I felt it was a clear conflict of interest for me to sit in on his parole board hearing. I also was not sure how I could stay impartial as a researcher with a case I had worked on so closely.

6.2.4. Record of Decisions

In order to obtain a sample of formal parole decisions, I was required to complete a Request for Registry of Decision. As these documents are publically accessible, I did not require ethics approval for access and analysis of public documents. I registered with the PBC to obtain all records of decisions from male offenders from the 2013-2014 fiscal year. The PBC offered a sample of 25 cases per release decision (day parole, full parole, and detention review) with an understanding that if I required more samples I could request such and I would receive more decisions. In total I received 75 random cases from the 2013-2014 fiscal year. However, after reviewing the 50-day parole and full parole decision, I decided that I could not separate day and full parole into two categories as the full parole decisions also included day parole decisions. Therefore, in an effort to have two clearly

defined samples and to reduce the large sample, I used the full parole category. In the end, I coded and analyzed a sample of 25 day/full parole cases and 23 detention reviews. As the PBC removed all identifiers related to the names and dates of the offenders being assessed, I entered XXX to depict that this information was formally removed. These documents were later analyzed for themes related to mental health. I also reach data saturation with the 48 records of decisions, meaning that near the end of coding, I reached a point where I did not need not see any new themes emerging in the data that I had not already identified. Therefore, I did not request further decisions from PBC.

Finally, I was originally provided 25 detention cases under my request for the decision registry. However, there was a duplication of one case and another detention case was for a woman offender. I believe this was an error on the part of PBC as my sample request was for male offenders. Therefore, I removed the duplicate case and also the woman offender in order to maintain the integrity of my sample population.

6.3. DATA ANALYSIS

Silverman (2006) describes basic content analysis as a methodology for "establishing categories and then counting the number of instances when those categories are used in a particular item of text" (158). He goes on to distinguish the similarities and differences between quantitative and qualitative content analysis methods. He notes that both methods rely on the reference to the cause or concept as the unit of analysis[55], however, quantitative studies rely on frequency and

[55] According to Babbie and Benaquisto (2002), units of analysis are "the individual units about which we make descriptive and explanatory statements" (287).

reliability of its measures, whereas qualitative studies focus on a thematic/narrative analysis when the unit of analysis is mentioned within a text (163).

The characteristics of content analysis make it advantageous to focus on a subject and its context from a latent and manifest perspective. The differentiation between latent and manifest content lends itself to a powerful analytic method to interpret not only the visible, obvious or "manifest" units of analysis related to my project but also provides the means to interpret underlying "latent" themes inherent in the data (Graneheim and Lundman 2003).

As noted above, there are few studies that have examined mental health and parole decisions, resulting in a scarcity of research on this phenomenon. The advantage of employing a content analysis of the data is that I can be directive in my data collection, I could review information directly related to mental health. However, the challenge was to draw boundaries at the level of concept development so that I do not become too narrow in my focus nor so wide that the nuances of the terms associated with mental health become lost (Miles and Huberman 1994; Hsieh and Shannon 2005). In other words, I was required to stay as close to the examination at hand as possible without becoming over extended.

It is believed that the various sources from which data was collected along with the directive focus of mental health in this content analysis raised the credibility of this research (Polit and Hungler 1999). In an effort to ensure that I did not inadvertently miss an opportunity to see other themes or categories emerge from the data (Grameheim and Lundman 2003), I openly coded the data prior to review for potential themes related to mental health. This will be further discussed in the next section below.

6.4. DATA CODING

All text documents and observations made during the interviews were coded and analysed using NVivo software version 10 by QSR International. NVivo is software that specializes in the coding of unstructured qualitative research data by identifying and integrating patterns and/or themes throughout text documents. The following documents were uploaded to NVivo:

- PDF versions of all the DP/FP and Detention review decisions
- Transcriptions of interview data
- Ethnographic Participant Observation Field notes
- Reflective Memos
- Public Government Parole and Correctional Documents

The decision registry documents were used in their original format. However, given the interpretive component inherent in the process of participant observation, all my notes derived from observing parole board hearings were transcribed and subsequently uploaded for interpretation of themes and/or subtle connections for close analysis of the textual data.

I relied on a first and second coding cycle (Saldana 2009), and an open versus focused coding process (Emerson, Fretz, and Shaw 1995). These similar coding methods will be discussed further below. I selected coding methods that best targeted my research questions. For example, I drew on Saldona's concept of "pragmatic eclecticism" which meant that I did not determine my coding methods until after I had collected and then reviewed the data (Saldana 2009, 47). In this way, I was able to remain relatively non-committal, or open, with regard to how to best proceed with my analysis after a first review of my data collection. More importantly, this approach remained true to the methodological underpinnings of my theoretical framework, namely symbolic interactionism. Symbolic interactionism rests upon two ontological and epistemological assumptions, 1) meaning is

derived from the individual as well as the cultural or shared forms of reality; and 2) given the interactional nature between the investigator and the phenomenon, meaning is created as the investigation proceeds (Tan, Wang, and Zhu 2003). Therefore, it was deemed important that I not pre-select my coding methods until I indeed recorded and reviewed the data, especially the raw data that involved participant engagement.

During the first coding cycle or open coding I engaged in the following coding methods: in vivo or open coding (Saldana 2009; Stringer 1999); attribute coding (Saldana 2009; Bazeley 2003; Gibbs 2002), simultaneous or co-occurence coding (Saldana 2009; Miles and Huberman 1994); structural coding (Namey, Guest, Thairu, and Johnson 2008; Saldana 2009), descriptive or topic coding (Saldana 2003; Miles and Huberman 1994); and finally dramaturgical coding (Goffman 1959; Saldana 2005, 2009). Saldana has further categorized various first coding methods into sub-categories. Table 5 illustrates a useful chart that guided my coding to ensure that the different coding methods drew on different aspects of the data:

Table 5 - First and Second Cycle Coding Methods[56]

[56] Saldana 2009, 46.

FIRST CYCLE CODING METHODS	SECOND CYCLE CODING METHODS
Grammatical Methods • Attribute Coding • Magnitude Coding • Simultaneous Coding **Elemental Methods** • Structural Coding • Descriptive Coding • In Vivo Coding • Process Coding • Initial Coding **Affective Methods** • Emotion Coding • Values Coding • Versus Coding • Evaluation Coding **Literary and Language Methods** • Dramaturgical Coding • Motif Coding • Narrative Coding • Verbal Exchange Coding **Exploratory Methods** • Holistic Coding • Provisional Coding • Hypothesis Coding **Procedural Methods** • OCM (Outline of CultUral Materials) Coding • Protocol Coding • Domain and Taxonomic Coding **Theming the Data**	• Pattern Coding • Focused Coding • Axial Coding • Theoretical Coding • Elaborative Coding • Longitudinal Coding

The following section will describe each of these coding styles I used in this dissertation as well as how I applied the coding method to analyse my data.

6.4.1. Open Coding

Open coding or *in vivo* coding is an elemental method of coding the data (Saldana 2009). It involves coding the actual words of the participants in an effort to capture how the individual interprets specific terms, metaphors etc. This method is instrumental in understanding how participants use concepts on the front lines or in their everyday language (Stringer 1999).

There were three data sources that permitted me to open code: interviews, decision registry, and as well the parole hearings (when I was able to capture the spoken word in its exact form). When I coded the data in the interviews, I italicized the data in order to always be able recognize the voice of the person interviewed (Saldana 2009, 75). The reason for this is that when I uploaded in vivo data into N Vivo and conducted large queries involving all my data sources, I wanted to ensure that I was able to recognize when I was capturing the in vivo or participant driven data, namely the exact words of the participants.

Attribute Coding

Attribute coding is a type of descriptive coding that describes general or descriptive information of the field or the data set. It can involve participant characteristics or data variables that are of interest to the researcher (Saldana 2009). The large sample of decisions (48) was an obvious place to use categorical tables to interpret my data. Importantly, this method was key in cross referencing the concept of mental health in the decision registry with other variables that may not have been so obvious by reviewing data through other coding methods. As noted above in Table 5, I categorically coded parole board member characteristics from the parole board hearings I attended to these categories in an effort to analyze the influence of personal characteristics on the data.

Simultaneous Coding

Simultaneous or co-occurring coding is a descriptive coding method that underscores the value of coding a unit of analysis using more than one code (Glesne 2006). Some academics caution simultaneously coding may inadvertently lead to the researcher not having clear codes or understanding of their codes. Therefore the authors suggest that one should justify its use (Saldana 2009, 62; Miles and Huberman 1994).

The most obvious reason for my usage of simultaneous coding is that I did not want to neglect coding the concept within its context (i.e. hierarchal code) (Saldana 2009, 63). Since I am exploring how mental health is operationalized by parole board members, I had to be careful that my coding didn't limit my sample by isolating the coded information from the larger context. Instead, I wanted to ensure that I was able to examine the interrelatedness of mental health with other important concepts such as risk, diagnosis and or violence (these often came up together in the data sources). For example, the following is a quote from one of my interviews with a former parole board member, "(…) especially if that involves violence, and often people with mental health issues will try to self-medicate through, you know, improper use of medications, or illicit drugs, or alcohol, and a lot of times that the people that are receiving medications for mental health issues don't like the side effects". In this quote I code for violence, medication, drugs/alcohol, and mental health. Isolating this passage to one code would compromise the inter-relatedness of all the concepts associated with mental health.

As well, I coded the parole decisions backwards by beginning at the end. There were two reasons of this. First I wanted to ensure that I read the documents in an effort to deconstruct them. The manner in which the decisions are written moves the reader through the document so that the

end seems like a logical ending. It is difficult to come to a different understanding of the data when it is a read as a convincing argument. Instead, in my first coding cycle, I wanted to capture specific words through my content analysis without too much attention paid to how the parole board member was rationalizing the concept. Instead, I was coding for the actual word.

Descriptive Coding

Otherwise known as topic coding, descriptive coding is essentially identification of the data into one word as a running record of the data. These codes can then be classified into "parent" and subcode "children" codes (Miles and Huberman 1994; Saldana 2009, 72). For example, in the data I coded for all references to specific mention of a mental diagnosis, i.e. Borderline, Bipolar Disorder. However, I coded all these "children" codes under the "parent" code of Diagnosis. This was an efficient way to keep these codes organized for later analysis.

Structural Coding

As described by Saldana (2009), "[s]tructural coding is a question-based code that 'acts as a labeling and indexing device, allowing researchers to quickly access data likely to be relevant to a particular analysis from a larger data set' […]. Structural Coding both codes and initially categorizes the data corpus […] perhaps more suitable for interview transcripts than other data (67). For example, using this coding method I took large segments of text from my interviews and linked the passages with my research questions for later analysis. I coded the entire section of data, in order to capture the entire thought and/or conversation between myself and the participant.

Dramaturgical Coding

Dramaturgical coding is a coding method used to explore themes related to how the participant interacts, understand, and/or manages conflict (Saldana 2009, 103). This type of coding provided an avenue to gain insight into the culture within which the parole board members,

offenders, and observers interact when participating in parole hearings. I used this type of coding in my field notes and memos that I completed about my observations of the parole hearings. When analyzing my notes, I paid attention to the different objectives of the offender (participant-actor) and the parole board member (participant-actor) in an effort to understand the power relationship throughout the hearing by way of shifts in communication, demeanor etc. (Saldana 2009, 105). Throughout my field notes for example, I coded "actor" or "ritual" whenever a participant involved (even if it was a hearing officer) identified a process or made reference to the authority of the decision maker or the authority of the process. I will present these findings in Chapter Eight where I discuss the informal properties of decision-making. I found that Goffman's (1959) theoretical concept of social identity[57] immediately resonated with me when coding through this method. For example, when the offender arrives to the hearing, he comes with the objective of convincing the board that his risk can be managed in the community. His file has already been reviewed and he is subsequently presented by his case management team through a specific lens. Accordingly, through a set of constructed risk and social factors, the board has already attributed a certain social identity to the offender even before the offender, as the institutionalized other, was interviewed. Moreover, the offender's responses in the hearing, the reactions to one another during the hearings, background information of the participants, and even how the offender's life is described through his criminal history were all ways to code to understand the power relations at play. Overall, I

[57] According to Goffman (1963): "Society establishes the means of categorizing persons and the complement of attributes felt to be ordinary and natural for members of each of these categories. […] When a stranger comes into our presence, then, first appearances are likely to enable us to anticipate his category and attributes, his 'social identity' […] We lean on these anticipations that we have, transforming them into normative expectations, into righteously presented demands. […] It is [when an active question arises as to whether these demands will be filled] that we are likely to realize that all along we had been making certain assumptions as to what the individual before us ought to be. [These assumed demands and the character we impute to the individual will be called] *virtual social identity*. The category and attributes he could in fact be proved to possess will be called his *actual social identity*". (2)

analysed how the various actors' participation, as well as the structured stage process contributed to the risk assessment.

6.4.2. Second Cycle Coding

I began with over 100 codes, which were subsequently reduced to 49 during my second cycle coding. I must emphasize that over half these codes were specific mental disorders that I was required to understand as stand-alone units of analysis. I spent considerable time reviewing the codes, refining, and amalgamating codes to ensure a cohesive coding cycle. I had to recode entire nodes numerous times in this process through this reconfiguration. This was an onerous process as I had a large sample for this sort of analysis. Moreover, I often verified my coding through word queries and text searches using NVivo 10 software. If I could not verify that the node represented all available data, I always recoded the data set, which resulted in new configurations of parent and child nodes.

As themes emerged from the sample, it became considerably difficult to keep reviewing their relation to one another as the themes became quite coherent in their own unit. I knew at that point that I had a solid thematic to begin to work with. I also conducted a pattern matching analysis that consisted of linking the data to my theoretical concepts, such as risk and/or risk factors (Saldona 2009). For example, I recognized that a significant portion of substance abuse was framed through a risk factor analysis; however, coding substance abuse as a risk factor would not have allowed me to understand the larger context within which substance abuse was raised. Therefore, I ran text queries and word trees to ascertain the broad spectrum of a parole board member's understanding of the construct. These results became the substance abuse chapter, located within Chapter Seven: Mental Disorders.

Chapter 7. Discussion of Findings

Section One: Discussion of Data

This section details my observations of the data and analysis of how mental health problems, specifically mental disorders as defined by the DSM-5, were represented in parole decisions. I first provide a review of the manifest data, such as the number of times mental disorders were referenced and the type of mental disorders referenced. I then discuss more latent content identified from the data and describe how these themes are implicated in the construction of mental health problems in decision-making. These themes highlight especially the influence of the psychological assessment in the decision-making process and the role of the expert in the determination of mental health problems. Furthermore, the findings suggest that the offender's ability to self-regulate their mental health is a critical component of the decision-making process as it relates to mental health, and I draw on the theme of medication as an important factor that informs decision-making.

Section Two of this chapter moves to a more directed analysis as I explore how parole board members operationalize mental disorders. This section outlines how diagnostic labels are framed and drawn upon in the decision-making process. I also discuss how parole board members reconceptualise disorders such as gambling addiction, sexual paraphilia, substance abuse, and psychopathy as risk factors in their decision-making. Although psychopathy is not a mental disorder as per the DSM-5, it is a diagnostic label designated by a psy or clinical expert.

7.1. MENTAL DISORDERS IN PAROLE DECISIONS

I employed a directive content analysis in order to identify all references to mental disorders as per the DSM-5. My data set consisted of 25 day/full parole decisions[58], 23 detention reviews, 17 hearings, and 4 interviews with parole board members. The following is a breakdown of all the references to a mental health diagnosis as per the DSM-5 in my sample. In all, there were 62 references to a mental disorder, and Table 6 is a representation of this manifest data:

Table 6 - References to Mental Disorders in Data Sample

[58] One of the DP/FP cases was a decision to "Change Condition" for the removal of a special condition to see a psychologist within the community while on conditional release. I elected to keep this decision within the set given the subject matter; the board would have to analyze the offender's mental health problems in order to remove the special condition.

Nodes	Number of references
Diagnosis\Substance Induced Mood Disorder	1
Diagnosis\Schizophrenia	1
Diagnosis\Poly Substance Disorder	2
Diagnosis\Personality Disorder	3
Diagnosis\Pedophilic Disorder	5
Diagnosis\Paranoid Personality Disorder	1
Diagnosis\Organic brain damage	1
Diagnosis\Obsessive Compulsive Disorder	1
Diagnosis\Narcissistic Personality Disorder	4
Diagnosis\Histrionic Personality Disorder	1
Diagnosis\Generalized Anxiety Disorder	1
Diagnosis\Gambling Addiction	10
Diagnosis\Prenatal Exposure to Intoxicants	1
Diagnosis\Depression	11
Diagnosis\Bipolar	4
Diagnosis\Antisocial Personality Disorder	10
Diagnosis\ADHD ADH	5

Out of the 48 cases in the decision registry, there were 18 cases in which parole board members referenced a mental disorder as per the DSM-5. This equated to 11 out of 23 detention cases and 7 out of 25 DP/FP cases[59]. For the detention cases, six out of the 11 cases had references to multiple diagnoses (comorbidities) as per the DSM-5. All 23 detention cases resulted in a negative decision and six out of the seven DP/FP cases that referenced a mental disorder were denied conditional release. Overall, 12 out of the 25 DP/FP cases were granted conditional release, keeping in mind that one of the DP/FP decisions were for a "Change Condition" decision and did not render a grant or denial of conditional release decision.

[59] Every detention review warrants an updated psychological risk assessment which is important to consider when reviewing these numbers. The implications of this psychological risk assessment will be discussed in the findings.

Out of the hearings that I observed, there were six cases that referenced a mental disorder; two cases made reference to neurological assessments. In two cases, the parole board member asked the offender about suicidal behaviour or ideations by way of statements, which represents an associated feature for certain mental health disorders but not a distinct diagnosis. However, very little is discussed following this line of questioning as the offender quickly minimizes the file information as context specific, i.e. feeling overwhelmed upon admission to a penitentiary.

All four cases that referenced pedophilia were detention cases; one was during my observation of parole hearings and the other three references I identified in the decision registry. All four cases referenced pedophilia as the only mental disorder within the decision. All four cases were denied conditional release. The three references to Bipolar Disorder always co-occurred with reference to other mental disorder(s). All references to Bipolar Disorder were identified in the decision registry and all the cases were denied conditional release or were detained. In the detention cases, a general category of mental illness or mental disorder was often mentioned when the parole board member referenced the psychological report. General references to the term mental illness were included, but contextualized as to how the parole board member was operationalizing the term.

With regard to personality disorders, I coded according to the general category of "personality disorders" distinct from specific types of personality disorders. Overall, there were five codes (referred to as nodes within NVivo) for various forms of personality disorders: personality disorder, paranoid personality disorder, narcissistic personality disorder, histrionic personality disorder, and antisocial personality disorder. The group of codes for personality disorders were not simultaneously coded, which means that I did not code both the general personality disorder as a parent node and then the sub-categorical personality disorder (e.g. Personality disorder and Antisocial personality disorder) as a child node. Instead, I created distinct nodes for each mental disorder referenced by the parole board members. Therefore, Table 6 above is reflective of the total number of references to

actual diagnostic or mental disorders as per the DSM made by the parole board members. I included one reference to personality disorder that was made by the parole officer during a hearing because the statement was cited within an exchange with the parole board members. I did not code terms that referred to psychological traits such as narcissistic or histrionic as mental disorders. I coded this content under the parent heading of mental health characteristics. In keeping with the methodological underpinning of this study (i.e. content analysis), I have represented all data in its raw form as it was articulated either within the parole hearing, interview, and/or record of decision.

If one were to solely consider that there was a higher percentage of denials in the DP/FP cases when parole board members referenced mental health diagnostic information, one could argue that this finding supports the differential treatment thesis. However, when I compared the DP/FP data to the detention data, I found that there was almost no difference in outcome rates in the detention cases in reference to mental health problems. When I further deconstructed the data, I found that it was not the mere presence of a mental disorder that had a significant influence on detention decision-making. Rather it was 1) the type of mental disorder identified in the offender's dossier; and 2) the offender's management of the mental health problem. Interestingly, examining the data as a whole , I found that as the level of violence associated with the offender's criminal profile went up, the more likely the parole board member drew upon and discussed the offender's mental health in their decisions to deny, especially with regard to how the offender did or did not manage their mental health problems.

What follows is my analysis of these two key findings, specifically by examining the four key themes that emerged from the latent data. This contextual examination is a considerably different approach to analysing decision-making and goes beyond the outcome based manifest analysis. Here I provide critical new insights that add to the existing literature relating to the construction of mental health problems in the decision-making process.

7.2. THE PSYCHOLOGICAL RISK ASSESSMENT

As evidenced by Table 6, parole board members referenced diagnostic information as per the DSM-5 within the decision-making process. This rate was significantly higher for the detention cases than the DP/FP cases. I speak to possible explanations as for this difference later in the theoretical chapter. Aside from two DP/FP cases, all references to diagnostic information was written systematically into the same section of the record of decision, namely when parole board members are accessing the psychological risk assessment[60] report and discussing actuarial scores linked to the offender's profile. The psychological report also contains the statistical risk information that is important for risk assessment. The parole decision-making framework directs parole board members to anchor their decision in the actuarial risk assessment. Thus, the psychological risk assessment is an important document for risk-based decision-making by parole board members:

> The initial step is to determine an offender's likelihood of re-offending. This is best obtained from a review of a validated risk instrument (one that is appropriate for the type of offender; so a sex offender requires a specialized sex offender risk assessment) […] *Within* a risk grouping, there are factors that might influence a Board member's determination of an offender's suitability for parole. This is the purpose of reviewing the case domains. This means that the Framework integrates group-based estimates of risk such as determined by the SIR-R1 and other risk instruments with a case-specific analysis of an offender's suitability for release. In general, it is preferable to consider the more conservative risk estimate in the case of multiple (appropriate) instruments. This risk assessment becomes the anchor for the parole decision but is not the *actual* decision (i.e., some low risk cases might be denied parole and some high risk cases might be granted parole, based on the subsequent analysis). (Serin 2011, 3)

In the majority of cases, the references to diagnostic information or mental disorders was presented within the actuarial risk section of the written decision. When I first analyzed the data, I could not account for why the parole board members combine diagnostic information/ mental

[60] Psychological risk assessments are "an evaluation of offender risk, needs, responsivity and the manageability of risk, done from a psycho-social perspective, utilizing a variety of scientifically-validated assessment methodologies in an integrated process. It also includes reference to appropriate strategies for the management of risk" (PBC 2015).

disorders with actuarial data in the same section of their analysis. This pairing of information seemed contrary to the structured framework that guides parole board members to anchor their decisions in the actuarial score, especially since some risk assessment instruments specifically require determination of a mental disorder as a factor in calculating a risk score. Meaning, if the diagnostic label was relevant to the construction of risk, it was already included in the actual score's determination of that risk. In fact, this study found that parole board members draw on the diagnostic information/mental disorders systemically in their decisions to inform their construction of the offender as a risk subject.

Parole board members have a vast amount of data that they must review in order to render a decision[61]. In assembling their decision, parole board members systematically extracted data from the psychological assessment related to 1) mental disorders and; 2) actuarial scores to determine the offender's general risk profile or risk assessment (i.e. low, moderate, and/or high risk). This was especially the case in detention cases where policy directs a parole board member to examine a psychological assessment of the offender for each review. This data extracted from the psychological assessment was <u>always</u> written into the same section (if not the same paragraph) within the decision registry:

> In a psychological assessment conducted in XXX, the specialist made the following diagnosis impressions: sensitivity to a dependence on intoxicants, generalized anxiety disorder, traits of obsessive/compulsive disorder and antisocial personality with underlying narcissistic traits. In terms of the actuarial tools, you pose a moderate to high risk of violent recidivism which may significantly increase if you associate with negative peers. (Detention 9)

[61] In one informal discussion, a parole board member informed me that the board members must sometimes review dozens of case files (each containing numerous documents) and depending how long an offender is incarcerated, there is simply an enormous volume of information to sift through before interviewing the offender.

If we consider the considerable weight that parole board members are directed to give to actuarial scores in order to provide an objective risk level, one would question the alignment of mental health symptoms and diagnostic information with actuarial scores. This combination also seems contrary to the over-arching positive risk research that suggests that mental disorders are, in and of themselves, not one of the central eight risk factors or relevant to actuarial data that should "anchor" risk assessments (Andrews and Bonta 2007). Moreover, there was a systematic flow to the parole decisions, in which all decisions took considerable effort to detail any and all of the central eight risk factors throughout the remainder of the decision. I had expected to see information related to mental health presented throughout this section- as a criminogenic risk factor, not combined with actuarial risk scores. However, there was a clear pattern to suggest that parole board members constructed a risk profile based on both the conceptualization of mental health problems and the actuarial score. The following excerpts from the decision registry illustrate this argument:

> The psychological assessment completed in XXX for detention review, do (sic) not indicate the presence of symptoms of psychotic or severe mood disorder. According to the psychologist, previous assessments diagnosed a variety of disorders and you seemed to present a complex clinical symptomatology. Several of the symptoms and the disorders reported can be predominantly related to prenatal exposure to intoxicants. The resulting outcome seems to be primarily related to the detrimental effects on the central nervous system and the neuropsychological consequences. The psychologist indicates that a broad range of symptoms can result from prenatal exposure to intoxicants that may include cognitive, emotional and behavioural abnormalities and cognitive deficits. Social perception and skills can be impaired, as well as communication and adaptive skills. The persons affected may have difficulties to properly function in unstructured environment. They often have a poor concept of personal boundaries. They may have difficulty to link a cause with the effects or the consequences. As a result, they may have difficulties to learn from past experience and from consequences of their behaviour. They are often sensitive to social influences. Some researchers have observed a relatively high frequency of mental health problems, employment problems, difficulties with independent living, trouble with the law, and inappropriate sexual behaviour. The myriad of symptoms reported is likely to lead to social maladjustment. Taking that in account, the psychologist deferred his diagnostic impression. He added that a comprehensive neuropsychological assessment would be indicated in order to clarify the symptomatology and the possibility

of neuropsychological impairment. During the assessment, the risk of sexual and violent recidivism was examined using actuarial and clinical risk assessment scales (Static- 99R, Stable-2007). Based on the results obtained, the medium-term and long-term risk of sexual recidivism was deemed high. The results also indicated a very high priority for supervision. (Detention 14)

You were assessed on the Institutional Mental Health Initiative on XXX, and were found to be elevated on various clinical scales including: obsessive compulsive tendencies, interpersonal sensitivity, depression, anxiety, phobic anxiety, psychoticism, and global distress level. You reported feeling depressed, anxious and stressed out while in prison. You reported taking two kinds of psychotropic medications at that time. You reported a history of suicidal thought from approximately 20 years ago that you had not acted upon. You stated that you were housed at a psychiatric ward in XXX. File information indicates that you attempted suicide in XXX. File information reports that you were diagnosed with Bipolar Disorder in XXX, as well as Depression with Psychiatric symptoms, antisocial personality traits and poly-substance abuse. You denied current suicidal or self-injury ideations or plans. Consultation with the institutional psychologist on XXX indicated that you were non-compliant with your medication; you were counseled on the detrimental effects this would have on your health. You also reported that you had been selling canteen to buy drugs. It was assessed that you had very poor insight into your mental illness and would likely continue to be involved in the inmate drug subculture. On XXX, you further indicated feeling hopeless and were noted to be flat in your affect. You were also noted as being medication non-compliant, and admitted to using a myriad of drugs on the range. You told the psychologist that you were “starting to feel like I am crashing,” and being “sick of this rollercoaster.” You admitted to clear manic episodes, but were not convinced you suffered from bipolar disorder. In a Psychological Assessment dated XXX, the Psychologist determined (using actuarial measures HCR-20 and VRAG) your risk of violent reoffending to be within the moderate range. The Psychologist noted that your “level of risk increases significantly when he is noncompliant with medication, and when engaging in substance use. He has demonstrated a tendency to engage in erratic and aggressive behaviour during this term of incarceration, particularly when his mental health symptoms are not effectively managed.” It was suspected that your ability to remain medication-compliant within the community to be tenuous. The Psychologist concluded that you would “require a degree of monitoring and use of substances that would be difficult to provide. For this reason, it is believed that Mr. XXX poses a serious risk of causing significant bodily harm prior to his warrant expiry date.” (Detention 1)

The same month (XXX) the STATIC-99R and STABLE- Psychological Assessments reported your risk to re-offend sexually as being low and moderate respectively. Combined, your overall risk to re-offend sexually was deemed to be low. You were recommended for low intensity and moderate intensity sex offender programming. Your clinician was of the opinion that without appropriate and sufficient programming and follow up, you would

> likely be at risk to return to your former patterns of behaviour. In XXX, the Board cancelled your revocation with the same special conditions being imposed as per your initial day parole release. In rendering their decision, the Board noted that you accepted full responsibility for your behaviour while on release and expressed regret for your actions. You committed to participate in sex offender treatment programming in the community and enroll in a church-based pornography addictions program. Psychological file information dated XXX also reported that you had requested counselling services to assist in managing your chronic depression (DP/FP 15)
>
> A number of Psychological Assessments have been completed over the years and these all note that your actuarial scores all represent a low risk of re-offending. Your score on the General Statistical Information on Recidivism (GSIR) is 19, which places you in a category where 4 out of 5 offenders will not commit an indictable offence after release. A Psychiatric Report from XXX, diagnoses dysthymia with superimposed severe depression and delusional ideas, recommending psychiatric treatment and pastoral guidance. Another Psychiatric Assessment from October of XXX, after a month long assessment, diagnosed a history of major depression disorder - in remission; a history of dysthymia - in remission and a history of substance induced mood disorder - in remission. (DP/FP 20)

Based on these examples, the diagnostic information is drawn upon and constructed as risk information for the parole board member during the risk assessment process. Despite the realist risk literature that identifies mental disorder (schizophrenia or manic depression) as a minor or indirect risk factor in the determination of future recidivism, parole board members actually draw on any and all forms of diagnostic labels in their construction of risk. The next section will build on this finding, and examine how the expert is also implicated in this process of diagnosis.

7.3. THE ROLE OF THE EXPERT IN SUBSTANTIATING MENTAL HEALTH PROBLEMS

Through my observations, I noted that once mental health problems were determined through the expert assessment, these problems were constructed as "hazards"[62] or characteristics associated

[62] I am drawing on Fox's (1999) analysis of hazard within the risk assessment process. In his analysis, he argues that humans can be deemed hazards and this process is socially constructed based on a determination of empirical or scientific sources (1999, 21).

with risk associated with the offender. The parole board member draws upon the expert assessment to understand mental health as a possible problem. Once the expert determines there is a problem with the offender's mental health, the offender is expected to manage the assessed problem. My interviews with former parole board members confirmed this observation:

Shannon Ok, when you've reviewed cases for parole release, were there any flags or concerns that would be raised by mental health problems?

Participant A *Oh absolutely, in many, many, many cases, and so, sometimes we would see the flags being raised, and so, they'd be noted in the file that for things like: undiagnosed, or not compliant with treatment, or increased incidents of self-injury or major, you know, major depression post incarceration, so there will be all kinds of flags and sometimes we would, I would require assessments being done that were outside of policy. So, there was a psychological assessment on file that was less than two years old, you're supposed to rely on that assessment, but I would see a case where it was clear to me, at least I strongly suspected, that there was a mental health issue in play, I would ask for an updated assessment. This was not always well received.*

Shannon And, just to expand on that, what would that assessment do for you?

Participant A *Well… it would give me some degree of assurance, you know, if I was looking… if I'm making a decision on somebody's risk, and I have… and there's evidence throughout the file, not just for the index offence, but throughout this person's adult life, let's say, that there are mental health issues and I'm looking at no significant treatment plan and a psych assessment that might be 18 months old; I would want to know that a mental health professional had dealt with this person and was giving me their expert opinion on their health, so I want something more current.*

The role of the expert assessment was raised at the end of one interview with another former parole board member. In this interview, the former parole board member specifies the influence of expert opinion on their decision-making:

Participant B *Well, I think I'd pretty well cut it there. And I would emphasize in particular that I would place tremendous weight on the recommendations of the mental health specialists. And they would probably…if for example, the Psychiatrist is telling me that you are a high risk to commit another offense, I really don't care a hell of a lot about the other areas.*

Another former parole board member makes the same argument:

Participant D *I mean, certainly there was always a networking with other members and what kind of issues they were dealing with in their cases and mental health, which of course is always an issue, and seems like a lot of resources in the community regarding mental health is always an issue. We were not experts. We would certainly look for the information from the experts within the system, and when we were dealing with or the community, in dealing with it. Guidelines were important, what guideless did we have regarding mental health act, regarding the CCRA, regarding policies and procedures. The bottom line dealing with it all would be risk, and what is the risk for this person.*

With regard to the role of the expert within the decision-making process, another former parole board member presented somewhat of an outlier perspective. However, after analyzing the information it was clear that the quality of the work of the expert assigned to the region was the issue and not having access to reliable expert assessment for decision-making was frustrating for the parole board member:

Participant C *So, we went to, very often to… try to get outside psychiatrists who were not caught up in the system, they didn't feel obligated to the system. I think in many cases, for instance, I can give you one illustration; that was a XXX case, that I did the case prep in that, I went to 2 or 3 outside psychiatrists…thankfully I knew some of the other psychiatrists, so I would go to them informally and without mentioning an inmate's name give them the main issues involved, and ask them what their feelings were, what their thoughts were, and so on, but again I couldn't, because they weren't under contract or anything, I couldn't show them the file or anything like that, all I could do was give them, for instance "if… what would you think" type of thing.*

The authority to determine mental health problems appears to rest with the expert. Without the expert assessment and affirmation of the existence of a mental disorder, parole board members are less likely to recognize or substantiate mental health problems in their decisions. Once the parole board members ascertain the presence of a mental health problem, the offender is understood commensurate with how the expert assessment articulates the mental health problem.

There were even a few examples in which the parole board member referenced a psychological assessment that was based on a file review in lieu of interviewing the offender. In these examples, the expert's authority was still highly influential even without the offender's consent.

The following is an excerpt from the decision registry where the offender's consent and participation is not required in the determination of their mental health problems; however, the expert still provided a psychological diagnostic and risk score:

> A psychological assessment designed to assess your current risk level was initiated in XXX. You declined to participate in this assessment and so it was conducted in your absence (through file review and consultation with collateral contacts). The psychologist identified that you have been diagnosed with the following disorders: Attention Deficit Hyperactivity Disorder (ADHD), Antisocial Personality Disorder, and organic brain damage. The report concludes that your risk of violent recidivism is high, and cites your continued offending and lack of program completion as rationale for this conclusion (Detention 6).

In this example, the offender's lack of consent (as noted in the above decision by "declining" to participate in this assessment") is documented in the file as being non-compliant.

The professional/expert assessment plays a critical role in supporting claims about the offender's mental health. Since the psy professional is understood as the expert for substantiating mental health problems, the expert's professional opinion is the tantamount source of information for how the parole board member understand mental health problems. In total, there were 87 references to the keyword "psychologist" in the data set. References to the psychologist were made to substantiate one of three areas:

1) The offender's level of risk:

> The psychologist that wrote this report concurs with the risk level assessment contained in the Psychological Intake Assessment, and indicates that in her opinion your current risk level should be considered high (Detention 12).
>
> The psychologist deemed that without your participation in programs, your risk would be too high to be considered for any community release. (Detention 2)
>
> Your anxiety is being monitored by mental health professionals, and your psychologist has no concerns with your release (DP/FP 7)
>
> Based on the psychologist's clinical observations and the results of the administered measures, you present as a high risk for violent and non violent recidivism. Participation

in the Violence Prevention Program, the Family Violence Prevention Program and individual counseling were recommended. A recent psychological assessment completed in XXX, indicates your risk for reoffending remains in the high range. (Detention 13)

The psychologist notes you do not meet the profile of the type of person who should be detained until your warrant expiry date in order to increase public safety (Detention 17)

2) The offender's diagnosis:

The psychologist identified that you have been diagnosed with the following disorders: Attention Deficit Hyperactivity Disorder (ADHD), Antisocial Personality Disorder, and organic brain damage. The report concludes that your risk of violent recidivism is high, and cites your continued offending and lack of program completion as rationale for this conclusion. (Detention 6)

According to the psychologist, previous assessments diagnosed a variety of disorders and you seemed to present a complex clinical symptomatology. Several of the symptoms and the disorders reported can be predominantly related to prenatal exposure to intoxicants. The resulting outcome seems to be primarily related to the detrimental effects on the central nervous system and the neuropsychological consequences. The psychologist indicates that a broad range of symptoms can result from prenatal exposure to intoxicants that may include cognitive, emotional and behavioural abnormalities and cognitive deficits. Social perception and skills can be impaired, as well as communication and adaptive skills. (Detention 14)

3) The offender's level of adherence to his treatment plan:

> You attended three sessions with a psychologist with no concerns noted. The psychologist advised that no further appointments were warranted unless concerns were brought forward by your case management team (DP/FP 8)
>
> In addition, the psychologist recommended intensive psychotherapy and completion of a psychiatric assessment however, you made it quite clear that you are not interested to participate in sexual offender programming. In the psychologist's opinion, you have no insight into your criminality and show limitations to manage your sexual urges. The psychologist indicated that you have issues of fetishism and fantasies of forced group sex. At this juncture in your sentence, you have not participated in any programs. The High Intensity Sex Offender Program was offered to you but you refused to participate therefore, your risk factors remain unaddressed. In light of your low reintegration potential, a community strategy was not investigated although contact with the community parole officer was made. He supported your detention referral. (Detention 20)

It was only the expert, and not the offender himself, who could substantiate concerns related to mental health. For example, the presence of suicidal or self-harming behaviours are considered by CSC and the larger Canadian correctional environment as maladaptive behaviours associated with mental health problems (Power and Riley 2010; Dell and Beauchamp 2006; Wichmann, Serin, and Abracen 2002). How self-harming and suicidal behaviours are referenced within the decision-making process by the parole board members depends on the context within which the information was raised, as well as how the information was presented in the case management file. Through analysis of an *informal* conversation that occurred during one hearing, I identified how the parole board member and an offender interacted, frontstage, to construct meaning around the offender's placement under suicide watch. In this interaction, the parole board member draws on the fact that the offender was placed on suicide watch but has no other information to understand the incident. In this interaction, any concerns that the offender may have been suicidal or had suffered mental health problems are dismissed in large part because of the influence of the lack of expert interpretation of the incident. The following is a close description of this conversation between the

offender and a parole board member during the parole hearing. Note how the offender responds to a question in reference to his placement under suicide watch by minimizing the suicidal ideations:

PBM "You were in the special needs unit?"

Offender "-oh, the suicide watch? I said 'not yet' when they asked if I was suicidal"

PBM "what, were you angry?"

Offender "depressed at myself, sarcastic impact on my part, anger towards myself" (Hearing 14)

Here, the parole board member simply changes the subject after assessing whether to understand this as a hazardous area requiring further examination. Not only does the parole board member avoid specific reference to the label of suicide watch (instead stating that the offender was in the special needs unit); but had there been an psy assessment on file related to the incident, I argue that this interaction would have been greatly influenced by that assessment.

This same pattern of dialogue occurred in another hearing case, in which information about suicidal behaviour is referenced but dismissed shortly after the offender deflects any suicidal or self-harming intention, and the board members does not identify an assessment of the incident. In both cases, the board does not seem to give any further consideration to the incident[63]. The suicidal behaviour in and of itself is suggestive of mental health problems; however, without an expert assessment to identify and understand the mental health problems associated with self-harming or suicidal behaviour, the information is minimized by the parole board members. This further demonstrates the reliance of parole board members upon an expert assessment.

[63] There was a third case in the parole hearings that referenced "suicide" but it was in reference to a suicide bombing incident with regard to an offender serving time for a terrorism related offence. Given that I did not deem this consistent with the context I was using to analyze suicide and self-harm, I did not include "suicide bomber" within this particular query.

There were four references to suicide or self-harm in total within the *formal* decision registry; three out of the 23 detention cases and one out of the 25 DP/FP cases. In all examples, the board members drew on suicidal and/or self-harm behaviors documented in the psychological assessment to articulate suicidal or self-injurious behaviour among a myriad of other mental health problems:

> In a psychological assessment for segregation dated XXX the psychologist noted that you had attempted to hang yourself in the spring of XXX and participated in superficial cutting while at a psychiatric centre (dates unknown); you indicated no thoughts of suicide or self-harm at that time. You told the psychologist that you continued to hear voices, despite medication, but they did not cause you distress as you were able to manage them with help from watching television. You otherwise displayed no overt indications of mental disorder or impairment as defined by the DSM-IV. (Detention 7)

> You have a history of panic attacks and anxiety. File information indicates you attempted suicide in XXX; you have been managing well with the assistance of a psychologist. You have been open to using all of the resources made available to you while on conditional release (Full Parole 2)

In these decisions, the parole board members substantiate the suicidal and/or self-harming behaviour as indicative of the offender's mental health problems and align the information with other diagnostic expert opinions contained in the file.

On the contrary, little weight is extended to the offender's claim of mental health problems without expert corroboration. The following example highlights the offender's claim to his own mental health problems in the absence of expert assessment:

> Although you have reportedly made a suicide attempt in the past, there is no medical, psychiatric, or psychological evidence that you are likely to commit an offence causing death or serious harm due to a physical or mental illness or disorder. The psychological report dated XXX, concludes that you have "no thinking errors involving hostility toward women." (Detention 24)

The board member indicates that the offender "reportedly" made a suicidal attempt, suggesting suspicion regarding the validity of self reports, as the offender himself is not in a position of authority to make such a claim.

In this next example, the parole board member engages in a process of differentiating information about the offender's mental health. Here, the offender can only *report* and *state* their mental health problems as opposed to the expert assessment that can *assess, indicate,* and *diagnose* in order to substantiate the claims of mental health problems:

> You were assessed on the Institutional Mental Health Initiative on XXX and were found to be elevated on various clinical scales including: obsessive compulsive tendencies, interpersonal sensitivity, depression, anxiety, phobic anxiety, psychoticism, and global distress level. You reported feeling depressed, anxious and stressed out while in prison. You reported taking two kinds of psychotropic medications at that time. You reported a history of suicidal thought from approximately 20 years ago that you had not acted upon. You stated that you were housed at a psychiatric ward in XXX. File information indicates that you attempted suicide in XXX. File information reports that you were diagnosed with Bipolar Disorder in XXX, as well as Depression with Psychiatric symptoms, antisocial personality traits and poly-substance abuse. You denied current suicidal or self-injury ideations or plans. (Detention 1)

The following section will build on this section and review my observations of how parole board members consider the significance of mental health problems once they are documented by the expert. The areas of self-regulation and medication compliance were dominate themes related to how parole board members draw upon and reference mental health problems.

7.3.1. Self-Regulation

In many cases, parole board members referenced mental disorders more than once in the body of the decision. First, in the expert assessment and then later in reference to how well the offender was regulating the mental disorder by addressing the associated symptoms or behaviours. Consistent with PBC policy, if the parole board member incorporated the mental disorder in the decision-making process as a factor affecting self-control. The *PBC Decision-Making Policy Manual 2.9,* instructs parole board members to assess the presence of a mental disorder, sexual deviance, and substance abuse (all considered mental health problems for this purpose) as factors affecting self-control:

Assessing Factors Affecting Self-Control

9. Information considered when assessing factors affecting self-control includes:
   a. elements that relate to the offender's ability to regulate their own behaviour and the extent to which the offender is impulsive or easily angered;
   b. the presence of a mental disorder, sexual deviance or level of intelligence which interferes with the offender's ability to make law-abiding choices;
   c. the presence of substance abuse which prevents the offender from adequately controlling their behaviour; and
   d. information indicating that the offender is vulnerable to the influences of criminally oriented associates, possesses attitudes and values that support criminal behaviour or has anti-social personality or behaviour.

(PBC 2015, 2.9)

There are clear indications that parole board members engage in a process of assessment of how the offender is able to manage his mental disorder. For example, in one instance the parole member describes that "several of the symptoms and the disorders reported can be predominantly related to prenatal exposure to intoxicants. The resulting outcome seems to be primarily related to the detrimental effects on the central nervous system and the neuropsychological consequences" (Detention 14). The parole board member goes on to implicate the symptoms associated with Fetal Alcohol Spectrum Disorder (FASD)[64] as factors affecting the offender's (in)ability to control their behaviour:

> The psychologist indicates that a broad range of symptoms can result from prenatal exposure to intoxicants that may include cognitive, emotional and behavioural abnormalities and cognitive deficits. Social perception and skills can be impaired, as well as communication and adaptive skills. The persons affected may have difficulties to properly function in unstructured environment. They often have a poor concept of personal boundaries. They may have difficulty to link a cause with the effects or the consequences. As a result, they may have

[64] The process to diagnose FASD involves a comprehensive interdisciplinary team. There is a limited capacity to diagnose and treat individuals with FASD due to various factors required in the determination of FASD (Chudley et al 2005). In the example above, although the parole board did not directly refer specifically to FASD, the symptoms, behaviours, and consequences of the disorder are being implied.

> difficulties to learn from past experience and from consequences of their behaviour. They are often sensitive to social influences. Some researchers have observed a relatively high frequency of mental health problems, employment problems, difficulties with independent living, trouble with the law, and inappropriate sexual behaviour. The myriad of symptoms reported is likely to lead to social maladjustment. Taking that in account, the psychologist deferred his diagnostic impression (Detention 14)

I also noted an example in which the parole board member links the symptoms associated with depression to the difficulties the offender has with regulating their behaviour related to the depression:

> You were assessed on the Institutional Mental Health Initiative on XXX, and were found to be elevated on various clinical scales including: obsessive compulsive tendencies, interpersonal sensitivity, depression, anxiety, phobic anxiety, psychoticism, and global distress level. You reported feeling depressed, anxious and stressed out while in prison. You reported taking two kinds of psychotropic medications at that time. You reported a history of suicidal thought from approximately 20 years ago that you had not acted upon. You stated that you were housed at a psychiatric ward in XXX. File information indicates that you attempted suicide in XXX. File information reports that you were diagnosed with Bipolar Disorder in XXX, as well as Depression with Psychiatric symptoms, antisocial personality traits and poly-substance abuse. You denied current suicidal or self-injury ideations or plans (Detention 1)

In one hearing, the parole board member spends considerable time attempting to understand a psychological condition affecting his ability to control his behaviour. The following is a description of the conversation between the offender and the parole board member:

PBM	No follow up; no appointments?
Offender	I didn't follow up
PBM	Didn't this scare you? Lost days but not enough to pursue counselling?
Offender	Just here (points to chest), kept there
PBM	Describe blackout period, psychogenic fury? Stressed induced? Were you exposed to violence/trauma?
Offender	Not even a victim of violence or around it
PBM	Ever read up on the diagnosis?
Offender	No but it is caused by stress, nothing about underlying psychological issues
PBM	This is concerning to your case management team and PBC that you don't know if it will happen again
Offender	I am a different person, not a busy person, can control anxiety, a lot of work to be a different person
PBM	Similar block after murder (referring to the criminal offence)
Offender	There was a difference between psychogenic fury and shock after my wife, I don't how I know but I do
PBM	Did you ever try to remember that day?
Offender	It may come to me at some point, asked a psychologist about hypnosis but I know what I did, the aftermath, what purpose would it be to be served with memories, I may have use for one day and then I will deal with it then. (Hearing 4)

In this example, it is clear that the parole board member has significant concerns with regard to the offender's mental health condition that renders him unable to control his behaviour.

Alternatively, there were two examples of cases that referenced depression where the parole board member drew upon the mental disorder as a means of illustrating how the offender had a grasp on the management of their behaviour. I identified these cases in the DP/FP sample. In these cases, the parole board member used the information to justify a conditional release:

> You have developed alternate strategies to deal with such things as social isolation, anger, and depression and you provided examples of some of those strategies to the Board. You identified feelings of isolation as your primary risk factor. You said that you are currently managing any symptoms of depression and you utilize various strategies to deal with it on an ongoing basis. (Day/Full Parole 20)
>
> Psychological file information dated XXX also reported that you had requested counselling services to assist in managing your chronic depression. However, prior to counselling, you were released into the community when your direct revocation was cancelled. Your Assessment for Decision dated XXX notes that you are presently on anti-depressant medication with no indication of any mental health issues impacting your risk while in the community. (DP/FP Parole 15)
>
> You have a history of managing well with the assistance of a psychologist (DP/FP 2)

My interviews with parole board members confirmed that an offender's demonstrated ability to manage their mental health problems was deemed favourable for release:

Participant A *Well, ok… going right back to the beginning about the kinds of things that I would look for in terms of engagement in present time and place and being confident, being self-aware, all those things, if those… if there is some evidence of those things in place I think that's positive, I mean… I think they are positive for me, let alone for somebody who's emerging from conflict with the law so… that's one thing, and the other thing is, if somebody is acknowledging their illness and engaging in treatment, so medication compliance is the easiest example, then again that would be a positive indicator for me that would be encouraging, as opposed to somebody who's either in denial or somebody who had a history of being non-compliant with the medication.*

Shannon Ok… are there cases in which mental health problems may negatively have impacted, I know that you drew on it a bit, but are there specific diagnoses or behaviours that usually present the flag that later you can't really reconcile in order to…

Participant A *you know what… I wouldn't say that there is any one condition or diagnosis that would automatically be the, you know, the single deciding factor, the single issue. It's really about who that person is, how they are dealing with the illness, what their diagnosis is, what their health providers are telling us, what the personal history is in terms of compliance with treatment, etcetera, and the other kind of community supports that may be in existence…*

7.3.2. Medication Compliance

As seen in the example above, another way the parole board member assesses for self-regulation of the offender is through compliance (or non-) with their medicine regime. This was a

strong theme in the latent data. In fact, the linkage between references to mental disorder(s) and whether the offender was taking medicine as a management or intervention strategy appeared to be the sole reason the parole board members referenced medicine prescribed to the offender. Mental disorders such as Bipolar Disorder, Schizophrenia, and/or Anxiety disorders, sometimes referred to as "psychiatric" disorders, would be implicated here by way of the use of psychopharmaceuticals to manage the disorder. Using a word tree, I analyzed the different contexts in which the word "medication" was used. The graph depicted in Figure 1 is a sub-section of a word tree based on the query word "medication".

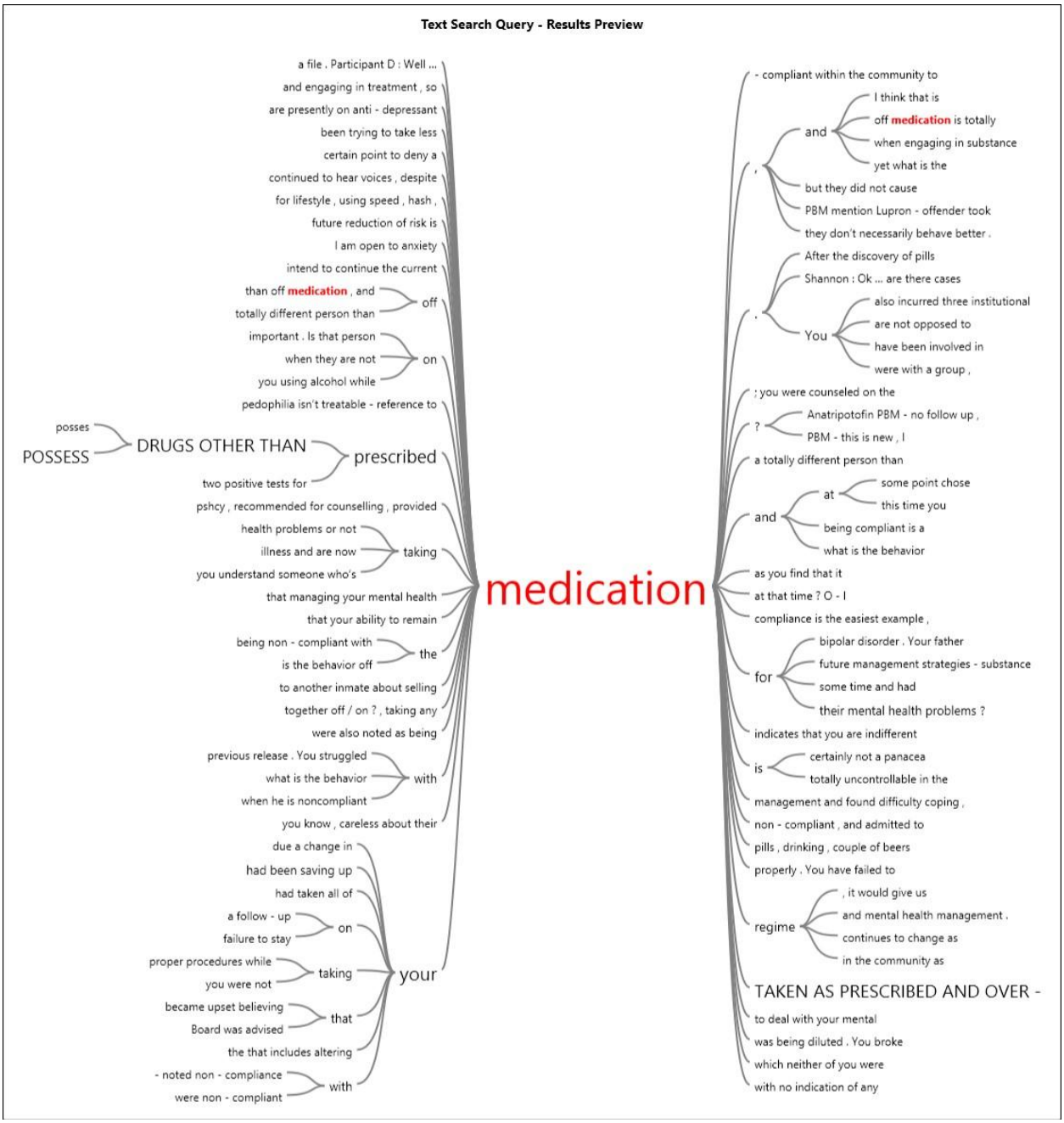

Figure 1 - Word tree sub-section for "medication"

The font size within the graph illustrates how often words are used in relation to others words associated with the keyword "medication". This graph provided a strong visual of the references to the keyword "medication" in the data set. Based on a review of the data and noting how the phrase "possess drugs other than" is in large font, I observe that the keyword "medication" is applied most

often in the articulation of a special conditions[65] imposed on the offender's release. Within this specific context, the word "medication" is referenced as part of a phrase to restrict the offender's consumption of drugs and alcohol:

> NOT TO CONSUME DRUGS NOT TO CONSUME, PURCHASE OR POSSESS DRUGS OTHER THAN PRESCRIBED MEDICATION TAKEN AS PRESCRIBED AND OVER-THE-COUNTER DRUGS TAKEN AS RECOMMENDED BY THE MANUFACTURER. (DP/FP 20)

Other scholars (Hannah-Moffat and Turnbull 2009) conducting research in the area of parole conditions in Canada have found that parole board members routinely apply conditions related to the theme of consumption. Specifically, they apply a restriction of this theme of consumption of illicit drugs and alcohol on the offender's release. Within this theme, the offender is also regulated through special conditions related to the consumption of medication as part of a psychiatric regime. This observation was not found in this data set. One plausible explanation is that less than half of the decision registry was detention cases and therefore, special conditions were not applied to their cases as all the detention cases resulted in a detention order.

When I reviewed the special conditions applied to the nine DP/FP cases that referenced mental disorders and were released on some form of DP/FP, there was not one special condition to regulate the offender's medication. This does not suggest that this special condition is not used to regulate the mental health of offenders though medication, but perhaps the absence of such conditions in my data set could be explained by gender differences. Hannah-Moffat and Turnbull's study that found special conditions mandating medication usage focused only on women offenders. I will speculate on this in my discussion later in the dissertation, but it could have something to do with the increased use of psychological interventions in the management of women's corrections.

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[65] When released on any form of conditional release, offenders are assigned certain conditions referred to as "special conditions". These conditions place restrictions or articulate instructions regarding the offender. These conditions are assumed to manage the risk posed by the offender while on conditional release.

By eliminating the references to medication related to special conditions, the word tree was a powerful way to illustrate how parole board members referenced the keyword "medication" in the remainder of the cases within the decision registry. Within this set, I found that there were two overall themes related to how the word medication was referenced:

1) compliance of the offender with his medicine regime; and

2) the use of medication in the management of the offender's mental health.

Overall, if the parole board members are not referring to the special conditions applied to the offender's release, they draw on medication as a management tool in the regulation of the offender's mental health.

Within the decision-making process, the offender's compliance with a medication regime is critical for the parole board member's conceptualization of the offender's mental health problems as being a risk or not. The following example highlights this differential impact of medication compliance versus non-compliance:

> You were also noted as being medication non-compliant, and admitted to using a myriad of drugs on the range. You told the psychologist that you were "starting to feel like I am crashing," and being "sick of this rollercoaster." You admitted to clear manic episodes, but were not convinced you suffered from bipolar disorder…He has demonstrated a tendency to engage in erratic and aggressive behaviour during this term of incarceration, particularly when his mental health symptoms are not effectively managed. It was suspected that your ability to remain medication-compliant within the community to be tenuous…The Board heard your complaints that your prescribed medications do not work for you, but is concerned by your overall failure to stay on your medication regime in the community as well as in the institution. This is particularly worrisome given your admission of being vulnerable to any suggestion of wrongdoing or crime, when in your "maniac stage". (Detention 1)

> You struggled with medication management and found difficulty coping, even with supports and assistance available to you. Ultimately, you were revoked for returning to illicit drug use and going unlawfully at large. This poor release history adds to the Board's concern in review of your case. (Detention 10)

Alternatively, parole board members also reference when an offender is compliant with medication:

> You also intend to continue the current medication as you find that it helps you to better control your aggressiveness. You therefore plan to meet with a psychiatrist for a follow-up on your medication. (Detention 9)

Two cases referenced the role of medication to regulate or control mental disorders within the parole hearings. One of these cases was a detention review hearing. After providing the offender with a negative decision to detain him for sexual deviance (pedophilia), the parole board member conveyed to the offender that medication would be advisable for his next detention review. The following is a description of the phrasing used by the parole board member to the offender:

PBM There is no good news; we are confirming the detention, although you were honest, and trying to work on yourself. I don't think you want to hurt anyone, but you are not to the point where you can be released, perhaps the potential use of Lupron[66] for the next and hope for the best.

So, in this example the parole board member directly implied that his chance of parole would increase if he was compliant with medication that could reduce his recidivism risk. This quote is significant as it provides insight into parole board members future oriented decision-making process and possible ways taking medication would influence future applications for his release. While it is already known that risk by definition is future oriented, it is deconstructing the context within the parole release decision-making process that makes this finding significant. As this research finds, it is not merely the presence or indication of mental health or mental disorders that influences the parole decision-making process but whether the offender is engaged in a risk mitigating practices, such as taking medication, to regulate the problem associated with their mental health.

7.4. PERSONALITY DISORDERS

According to the DSM-5, a personality disorder is "an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of an individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment" (APA 2013, 645). One significant issue with regard to analyzing the data related to personality disorders was that the risk and recidivism literature understands personality disorders as factors for analysis alongside other static (unchangeable) risk factors. One parole board member goes so far as to differentiate mental illness from personality disorders, "you have been diagnosed with mental illness and are now taking medication to deal with your mental illness. You

[66] Lupron is a drug used in the treatment of sexual offending behaviours to diminish sexual desires.

have also been diagnosed as suffering from an anti-social personality disorder" (DP/FP 1). This reference is a reflection of the fundamental assumption of the risk need responsivity (RNR) framework that informs risk assessment in Canada[67]:

> With respect to criminal behaviour, we refer specifically to an antisocial personality pattern. Antisocial personality pattern is not limited to the psychiatric diagnostic category of Antisocial Personality Disorder or the forensic label of *psychopathy*. It is more comprehensive and captures the history of generalized rule violation and trouble, some of the personality factors that function as criminogenic needs (e.g., impulsivity, self-centeredness) and responsivity factors (e.g., need for excitement, shallow affect) (Bonta and Andrews 2007, 13)

Moreover, in their assessment of the criminal, social, and conditional release history the PBC *Decision-Making Policy Manual 2.8(8)* also specifically cites personality disorder as a risk factor for analysis.

While outside the parameters of the main research focus, it is important to acknowledge the differences in the treatment of personality disorders versus other mental health disorders. This has important implications for how the offender has the potential to self-regulate or manage their mental health problem when the problem is assumed to be within the offender's personality. The previous editions of the DSM employed a "multiaxial" system for assessment and treatment. The DSM IV used Axis I disorders to categorize mental disorders that were characterized by acute or narrow symptomology. These can often be treated by way of medicine or psycho-pharmaceuticals. Personality disorders were identified as Axis II disorders in DSM IV. There is significant controversy related to the treatability of this category (Dingfelder 2004), historically being treated by way of cognitive or behavioral type of therapies. Under this multiaxial system, Axis III disorders present physical injuries such as brain or health conditions with unique treatment or management options and Axis IV are environmental or psychosocial problems that may influence treatment

[67] This is a larger issue within mental health and psy disciplines as well.

responsivity. A main issue in studying the management of personality disorders is that there is considerable concern related to the effectiveness of treatment for personality disorders (Bateman and Fonagy 2000). Therefore, there may be an assumption made by parole board members that a personality disorder cannot be managed because it is considered untreatable.

To add to the complexity of analyzing personality disorders within the parole decisions, I note that in all references to personality disorders and specific types of personality disorders, the offender was also diagnosed with other mental disorders as well (co-morbidities). However, when I reviewed the decisions as a whole, I note that parole board members drew on the behaviours associated with the personality disorder to support negative views of the offender's personality. Although this may seem like an obvious finding as socially disvalued behaviours are at the core of the construct, this research notes that it is how the parole board member draws on the label, namely as part of a list of other distinguishing abnormal or pathologized mental health problems the offender is unable to control as it is part of his personality. The expert diagnostic is implicit in this generalization of the offender's personality. This observation is not entirely surprising given the DSM-5 description of individual personality disorders. For example, according to the DSM-5 an individual diagnosed with narcissistic personality disorder would have shown "a pattern of grandiosity, need for admiration, and lack of empathy" (APA 2013, 645). The following is a passage from the decision registry:

> Your complete indifference toward your criminal behaviour and your victims has been clear in many of your statements and behaviours. You are unable to grasp the severity of your offence and blame the victims. You show a complete lack of consideration for the consequences of your actions and have no concern for the victims…No paraphilia was diagnosed. According to the psychiatrist, your inappropriate sexual behaviour stems from your antisocial and narcissistic personality, egocentrism, misogynous attitude, lack of empathy for women, and perception of women as sex objects (Detention 14)

In these examples, the offender is constructed as "unable" to comprehend or regulate his behaviour based on his pathology. Moreover, he is characterized by the parole board as "lacking" the insight

into his actions for which the parole board member is revealing his/her opinions related to the implied nature of the offender. Here, the parole board member is constructing the offender as an immoral individual, pathologized by his own personality deficits.

During Hearing 8, there was an interaction between the parole board member and the offender around why the offender had followed his girlfriend home the night of the index offence. The parole board member had indicated during this exchange that the offender had lied in the past to the parole board members; therefore, the interaction between the two actors was tense but the dialogue continued between the two. The parole board member pressed the offender about being dishonest, until he offender finally responded that he had lied in a previous hearing, "because of my narcissistic traits, make my way of things". From there, the board appeared to be satisfied that the two of them were able to come to some common agreement that the offender was a self-serving, lying, "narcissist". This interaction constructed how the offender was understood through his mental health and subsequently processed for a negative decision for conditional release.

Similarly, for anti-social personality disorder the DSM-5 notes that the person has met the threshold illustrating "a pattern of disregard for, and violation of, the rights of others" (APA 2013, 645). Offenders referenced as having anti-social personality disorder were similarly characterized by the following:

> It is evident that you have an inability to control your violent behaviour to the point of endangering the safety of others (Detention 1).
>
> You have a significant history of breaches and failure related offenses while under supervision in the community, demonstrating a pattern of non-compliance with imposed conditions and expectations (Detention 6).
>
> It appears that his offending rose from his well-entrenched antisocial attitudes in conjunction with difficulties in controlling his violent impulses and a long term substance abuse problem (Detention 21)

7.5. CONCLUSION

This section of the chapter moved beyond an outcome based analysis of parole decision-making to examine how parole board members reference mental disorders. I have argued that outcome based analyses of mental disorders do not accurately capture how mental health problems are understood in parole decisions. Generally, parole board members understand diagnostic information as a scientific hazard, and in doing so, parole board members draw heavily on expert knowledge to understand the risk associated with the mental health problems in their decisions. Related to this, I have discussed how little credibility the offender has in substantiating his own mental health problems. In other words, the expert is seen as a filter through which validity of information is established.

Finally, I examined how parole board members understand the risks associated with personality disorders compared to other types of mental disorders. This chapter has challenged the current literature on parole decision-making and mental health problems finding that it is not necessarily having a mental health problem that negatively influences parole decision-making, rather the extent the offender can manage or self-regulate the problem through treatment or medication appears to the deciding factor.

The following section further deconstructs the decision-making process by examining how parole board members understand the following mental disorders: *psychopathy*, substance abuse, sexual deviance, and gambling. These four diagnostic labels are used to present another key finding of this study, namely that parole board members did not necessarily operationalize mental health problems as depicted through the DSM-5.

Section Two: The Operationalization of Mental Disorders

The following section reviews four mental disorders that emerged as separate but inter-related concepts in the data set. Taking into consideration the lack of research in the area of parole decision-making, this exploratory study is an attempt to map out some preliminary understandings of mental health problems in parole decision-making. Drawing on the data set, albeit limited, this chapter builds on the findings from the previous section. What follows is an analysis related to how parole board members draw on various mental disorders and the unique ways in which each diagnostic label influences decision-making: gambling addictions, sexual paraphilia, substance abuse disorders, and psychopathy. This chapter addresses my second and third research question, namely how parole board members understand various mental disorders and how this information is used in decision-making. By the end of this section, I will have demonstrated how the diagnostic label, as conceptualized as treatable versus non-treatable is the single most important influence on decision-making.

7.6. GAMBLING AS A MENTAL HEALTH PROBLEM

Problems with gambling can be designated as a mental health problem in the DSM-5. Research in Canada and the United States has identified that 4% of the population has a problem with gambling, and 1% meet the criteria for a severe problem with gambling (Ferris and Wynne 2001; Room, Turner, and Ialomiteanu 1999; Shaffer, Hall, and Vanderbilt 1999; Wiebe, Mun, and Kauffman 2006)[68]. In contrast to these incidence rates in the general population, research suggests that problems with gambling affect approximately 33% of western correctional populations.

[68] Severe gambling problems could suggest that the level of dysfunction associated with gambling would meet the threshold to be classified as a gambling disorder by the DSM-5.

(Williams, Royston, and Hagen 2005) Recently, this area of research has come under closer examination as researchers attempt to quantify the relationship between gambling and recidivism (Lloyd, Chadwick, and Serin 2014; Turner, Preston, McAvoy, and Gillam 2012; Preston, McAvoy, Saunders, Gillam, Saied, and Turner 2012).

Gambling as an addiction was included in the DSM series in 1980. In comparison to the trajectory of other mental health problems, it is a relatively new disorder. A debate similar to that regarding substance abuse as a medical versus a dimensional model exists for gambling as a mental health problem. Blaszczynski and McConaghy (1989) have reviewed this debate, noting that the difference between the two is that the medical model categorically distinguishes pathological gamblers from non-gamblers based on personality profiles or biological correlates whereas the dimensional model argues that problems with gambling are best understood on a continuum (pathological gambler at one end of the continuum the occasional gambler at the other). As for treatment, the dimensional model rests upon social learning theories to target thinking that is related to the problematic behaviour, whereas the medical model advocates for full abstinence from gambling as a means to address the pathology (1989, 43). According to the National Center for Responsible Gaming (2012), the following are keys to the understanding of gambling disorders:

> • Gambling is an activity in which something of value — usually money — is risked on the outcome of an event where the probability of winning or losing is less than certain.
>
> • A gambling addiction is a persistent and recurrent maladaptive gambling behavior that disrupts personal, family or vocational opportunities.
>
> • Individuals who continue to gamble despite these adverse consequences, lose control over their gambling and crave opportunities to gamble likely are experiencing the clinical disorder known as gambling disorder.
>
> • Approximately 1% of the general adult population in the United States has or has had a gambling disorder in their lifetime.
>
> • An additional 2.3% have had some problems with gambling in their lifetime but have not met diagnostic criteria for gambling disorder.

> • Groups that are potentially vulnerable to developing a gambling disorder include adolescents, college students, casino employees and some minority populations.
>
> (NCRG 2012, 7)

As mentioned briefly above, correctional researchers have linked recidivism and gambling. Consequently, gambling has come to be understood as risky behaviour for the offender population, especially if problems with gambling exist alongside other mental health problems such as ADHD and depression (Turner, Preston, McAvoy and Gillam 2014). Consistent with research among non-offender populations, gambling interventions are encouraged to be clinical and comprehensive. Interventions administered in isolation without addressing comorbid mental health problems are seen as insufficient to manage the risk to reoffend (Lloyd, Chadwick, and Serin 2014; Turner, Preston, McAvoy, and Gillam 2012).

With regard to managing gambling behaviour, academics working in the area of correctional research identified that Canadian paroling authorities restrict women offenders who have problems with gambling from attending gambling establishments. Turnbull and Hannah-Moffat (2009) referred to these establishments as problematic spaces:

> Linked to the official characterization of paroled women as 'susceptible to crime' and 'risky' is the assumption that if they are in a criminogenic space, they will become criminals again. As a result, gambling and liquor establishments are seen as inappropriate spaces for *these* women if they want to be law-abiding. The parole narratives note that any 'slip' in abstention or entering these establishments could result in a return to crime. To prevent such relapses, the risky spaces themselves must be excluded from the array of legitimate spaces paroled women are allowed to occupy. This spatial mechanism of exclusion is used to dissuade women from drinking, gambling and associating with others who are engaged in these activities by removing the opportunities for such behaviours (Merry: 2001). The correct 'choice' for paroled women — as dictated by the special condition — is to avoid these criminogenic spaces. As such, the constitution of these establishments as 'risky' delegitimizes them as places for leisure, social interaction and even potential employment for these women. (2009, 544)

I found similar reference(s) in parole decisions related to how PBC regulated Canadian federally sentenced men on parole who had identified problems with gambling:

> File information indicates that you breached your financial reporting condition and engaged in gambling and attended casinos to deal with your financial stress. Monetary gain was also the motivation for your index offences. Special conditions relating to gambling are key risk management strategies in your case. (Day/Parole 16)

All cases that referenced gambling behaviour had a special condition to refrain from gambling and to not enter gambling establishments, or the problematic spaces. This condition was imposed on their release even if the board had deemed that the offender had addressed his problematic behaviour through treatment or abstinence.

7.6.1. Gambling: Mental Health Problem or Financial Greed

Out of the 65 cases for review (48 decisions from the registry and 17 hearings) and the four interviews, there were five cases that made reference to gambling. In these cases, although gambling was referenced as a problematic behaviour, the understanding of the problem was not consistently referenced as a mental health problem. I found that this was the interface between mental health and the regulation of "vice". In two of the five cases, gambling was referenced as an addiction whereas in the other three cases it was linked to financial stress/gain. For example, the following case depicts gambling as financial stress/gain:

> Your CMT had determined that large amounts of money were being withdrawn from your bank account without proof of your expenditures. In response to questions as to whether you were involved in gambling, you were initially evasive and then admitted that you had spent over $1000 at two casinos. You further admitted that you and your spouse were attending casinos in an effort to deal with financial stress (Day/Full Parole 16).
>
> File information indicates that you gambled to deal with anxiety and boredom, accumulated debts, and resorted to crime to pay back debts. Special conditions regarding gambling and avoiding gambling establishments are also key risk management strategies in your case. Your motivation to commit the index offences was greed. Reporting financial information to your parole supervisor about your income, expenses and debts will assist in ensuring that you are earning a living in a pro social, legitimate manner. (Day/Full Parole 21)

In the other two cases, gambling was referenced as a mental health problem. One of the two cases was from the sample of hearings that I observed. In this case, the entire hearing was framed around the offender's gambling addiction. In fact, his treatment while on bail and pre-sentencing negated him from taking any correctional programs as the treatment he took was understood to have addressed the addiction (problem behaviour). During the hearing, the board members asked the offender about his addiction as well as other issues linked to gambling. The following discussion was transcribed as accurately as possible during my observation of the offender and the PBC. The intention of this illustration is to highlight how the board engaged in a discourse around the offender's addiction with gambling:

Offender "I was lying to myself, family, addiction is only 15% of your iceberg, other reasons why gambling is to cope with stress, my unhappiness"

PBM "Wasn't it a recent marriage, not happy?

Offender "Loveless marriage, 2 kids. In the program we learned how we think, feel, act, learned coping mechanisms, science, dopamine, happy and excited, learned other ways, exercise, as a kid opposed to escaping to casino, Ms. Goodman (?) does cognitive therapy with me…

PBM "When you went to gambling program, what other issues did you have?"

Offender "I was unhappy, dropped out of school, disappointed myself, there was a time when money was gone and I was in a loveless marriage"

PBM "What other issues?"

Offender "I was trapped, gambling led me to be easily frustrated, angry with myself for not being able to stop"

PBM "In your programming, the report states that people can frustrate him, people can push him and could be wound up in a rage, easily agitated, extreme anger and rage [uses fingers to depict quotes], trying to determine what is meant by anger and rage, this program was after the index offence".

Offender "It was that anger that I felt, extreme, being back against the wall, looking for control, lying to mother".

(Parole Hearing 6)

It is suggested from the passage above that the parole board member links the offenders' gambling with factors that could increase the perceived risk, such as anger management issues. However, this interaction also illuminates how the parole board member and the offender interact to construct the offender as a moral individual. In the end, the offender is released on parole as he was able to convince the board that he was committed to a moral lifestyle, someone who although may have mental health problems, can also manifest insight into his previous vices and acknowledge his previous illegal choices.

7.6.2. Gambling and Abstinence

In both cases when gambling was referenced as a mental health problem, the offender was able to demonstrate an ability to manage his addiction or problematic behaviour to the point that the board drew on their mental health as a way to show responsibility:

> "You have focused on your new family even through all of the stressors you faced, and moved forward in an appropriate manner using all of the resources that were made available to you, indicating the ability to make proper choices. There has been no information to suggest a return to gambling or intoxicant use during this time. You have followed through with attaining your driver's license and this will alleviate the difficulties of finding a driver for you. Given the positive progress you have shown throughout your release on day parole, the Board is satisfied that you have made sufficient gains to present as a manageable risk on an expanded form of release." (Day/Full Parole 2)

Parole board members held abstinence, whether that was the result of treatment or simply personal restraint, as the goal for gambling regardless of how it was understood, through a mental health frame or as financial greed. The board examined whether the problematic behaviour had stopped. Did the offender engage in gambling behaviour or visit problematic spaces on conditional release? What was the offender's plan to avoid gambling in the future? When the parole board members queried why the offender gambled, it was not the salient factor for assessment. I found in all examples that referenced gambling, the parole board members sought to understand the offender's plan to remain abstinent and assess the viability of such plan.

Overall, however, I found that offender's insight into their gambling behaviour and their abstinence from gambling was deemed important for understanding how parole board members sought to manage the offender's risk, regardless of whether the behaviour was understood as a mental health problem or not. However, for the offender who had been diagnosed as having a gambling addiction, the expert's assessment that the treatment had contributed to the successful management of his mental health problem provided the offender with credibility and clearly influenced the decision-making process.

7.7. SEXUAL DISORDERS AS MENTAL DISORDERS

The DSM-5 recognizes sexual paraphilia as mental disorders. Recently, the American Psychiatric Association and other interest groups responsible for identification and classification of mental disorders made a distinction between sexual behaviour and preferences that meet the criteria for a mental disorder and those that are deemed "unusual sexual behaviour". According to the DSM-5, the following are characteristics of paraphilic disorders:

> DSM-5 requires that people with these interests:
>
> - feel personal distress about their interest, not merely distress resulting from society's disapproval; or
>
> - have a sexual desire or behavior that involves another person's psychological distress, injury, or death, or a desire for sexual behaviors involving unwilling persons or persons unable to give legal consent.
>
> To further define the line between an atypical sexual interest and disorder, the Work Group revised the names of these disorders to differentiate between the behavior itself and the disorder stemming from that behavior (i.e., Sexual Masochism in DSM-IV will be titled Sexual Masochism Disorder in DSM-5). (APA 2014)

According to the American Psychiatric Association, this purposeful distinction was made in order to avoid inappropriate pathologizing of consensual atypical sexual behaviour while at the same time, providing a diagnostic category for those persons who have sexual desires/behaviours for non-consensual sexual relations. Persons who are diagnosed with paraphilic disorders due to their non-consensual sexual desire/behaviour are often also subject to criminal charges. Furthermore, the sexual interest or behaviour for non-consensual sexual relations or sexual involvement with vulnerable populations was likely the determinant for the psychological assessment in the first place. These assessments are used as evidence towards identify and label certain sub-populations of offenders. This assessment for example, could result in a diagnosis of pedophilic disorder.

As Gordon and Grubin (2004) articulate, the area of forensic psychology has been the target of much criticism in its approach to assessment and treatment of sexual offenders. According to these authors, since sexual offenders are often managed within correctional and/or criminal justice fields the bulk of assessment is usually targeted at risk factors to reduce recidivism as opposed to psychopathological treatment aims:

> Assessment of the offender must include a psychosexual history of both sexual fantasy and sexual behaviour, but self-report is often unreliable. It is important to detect indicators of hypersexuality (for example, frequent masturbation and numerous sexual partners) and of sexual preoccupation or rumination (frequent or intrusive sexual fantasies, or subjectively uncontrollable sexual urges). The nature of the individual's fantasy life may indicate the presence of a paraphilia. Where a paraphilia is diagnosed, the frequency and level of intensity of the sexual fantasies should be assessed, including any escalation towards acting out the fantasies. In cases of mental illness, evaluation should determine whether the deviant fantasies developed concurrently with it, or preceded it and later became incorporated into it.
>
> […] It is important to differentiate psychological characteristics associated with risk of reoffending (for example, cognitive distortions) from those that relate more to engagement in treatment rather than to risk itself, such as denial or lack of victim empathy, neither of which has as yet been demonstrated to predict reoffending (Hanson and Bussiere 1998). It is also important not to confuse the role of actuarial risk assessment instruments, the best validated of which is probably Static-99 (Hanson and Thornton 2000), which perform better than clinical assessment in determining risk of reconviction in the long term, and clinical approaches to assessment, which are needed to identify treatment targets and to determine indicators of current risk. (Gordon and Grubin 2004, 75)

As observed in my data, I found that the differentiation between risk factors and psychological characteristics associated with treatment are often blurred by parole board members in their references to sexual offenders, if not entirely overlooked. I will explore this further in the following section using the case of sexual offenders within the data set who were also designated dangerous offenders. This exercise provides a useful way to illuminate how parole board members construct meaning about sexual deviance.

The Case of Dangerous Offenders

Dangerous Offenders (DO) or Offenders with Long Term Sentence Orders (LTSO) are offenders who have been labelled by the courts as meeting the criteria for displaying a pattern of not being unable to control their aggressive and violent behaviour and for this reason, they are subject to lengthy if not entirely indeterminate incarceration. One of the grounds for this designation is a failure to control one's sexual impulses (CC 753. (1) b):

> (b) that the offence for which the offender has been convicted is a serious personal injury offence described in paragraph (b) of the definition of that expression in section 752 and the offender, by his or her conduct in any sexual matter including that involved in the commission of the offence for which he or she has been convicted, has shown a failure to control his or her sexual impulses and a likelihood of causing injury, pain or other evil to other persons through failure in the future to control his or her sexual impulses.

In order to declare a person a dangerous offender based on paragraph B of the Criminal Code, the application to the courts must establish that the offender is unable or unwilling to control his/her aggressive impulses and therefore places a significant threat to public safety pursuant to CCRA S. 129 (9). During the process of review, the courts require psychological information to establish professional opinion (i.e. expert opinion) that testifies to the offender's sexual impulses. For instance, see the explanation in the Canadian Parliamentary Regime (2008):

> Before the court submits a dangerous offender or long-term offender application, experts in corrections and mental health must assess the offender's behaviour in order to establish a psychological diagnosis (20). In the case of a sexual offender, the sexual preferences and deviances will also be assessed. The assessment, which lasts a maximum of 60 days, is based on reasonable criteria for dangerousness (21) and on the possibility of supervising the offender in the community. The assessment report will be entered into evidence and the experts will be able to testify in court[69]. (Parliament of Canada 2008)

[69] For further information on the process, http://www.parl.gc.ca/Content/LOP/researchpublications/prb0613-e.htm.

Canadian federal correctional policy requires psychological assessment or psychological risk assessments[70] of incarcerated offenders for same purposes (if such an assessment is not already on file). As per the *PBC Decision-Making Policy Manual 2.2*:

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5. A psychological risk assessment is required for a review involving:
   a. persistent violence, as demonstrated by three or more Schedule I offences, which occurred on different days, where each conviction led to a sentence of at least six months duration;
   b. gratuitous violence, as demonstrated by excessive violence beyond that which is "required" to meet an end, or evidence of sadistic behavior or torture;
   c. a detention referral;
   d. conditional release for an offender with an indeterminate or life sentence; and
   e. a high risk sex offender. This may be in the form of a specialized sex offender assessment.

According to the legal and policy requirements, all detention cases should have a mandatory psychological assessment for decision-making purposes. Within my data set, I had the opportunity to analyze the files of four offenders who were designated Dangerous Offenders based on their repetitive sexual deviance within the decision registry for DP/FP and Detention. I presumed that analyzing this sub-group would provide insight into how psychological information related to sexual deviance was understood in the parole board members' assessment process as a psychological assessment is required reading for the parole board members for each of the offenders designated as Sexual Offenders Designated as Dangerous Offenders

In all four cases, the dangerous offenders in my data set had either previous convictions for sexual offences or were serving time for an index offence that was sexually motivated. In three of

[70] Psychological Risk Assessment (Évaluation psychologique du risque): "an evaluation of offender risk, needs, responsivity and the manageability of risk, done from a psycho-social perspective, utilizing a variety of scientifically-validated assessment methodologies in an integrated process. It also includes reference to appropriate strategies for the management of risk" (PBC Pol. 2.2 page 1).

the four cases, there was no diagnostic reference to sexual disorders or paraphilia disorders despite the parole board member assessing a psychological assessment. Instead, the content around a sexual offence or sexual behaviour was framed as problems of sexual deviance such as issues with impulsivity and/or cognitive distortions. In one decision, as the parole board member discusses the psychological assessment of the offender, he/she makes a distinction between the sexual behaviour and mental health problems:

> According to program and psychological reports the cognitive distortions around your deviant fantasies regarding children have not been adequately dealt with and you have not put cognitive or behavioural interventions into place that address these concerns. You need to realize that it is you that needs to manage your deviant urges and not excuse your offending on your mental illness. You fail to realize that you have deviant cognitions and beliefs regarding your deviant attraction to children that need to be addressed in sexual offender therapy separate and apart from your mental illness. (DP/FP 1)

In another case, the parole board member depicts the offender's return to sexual offending as being in his crime cycle, i.e. engaged in illegal criminal activity, through a legal rationality. There is no indication that the parole board member understand that his sexually deviant behaviour could be dysregulation of his mental health problems:

> Your offences demonstrate a high level of brutality and indifference to the victims… You have demonstrated, through your behaviour, a lack of empathy and understanding toward the consequence your actions have on others. The Board notes that you completed a sex offender program during your first federal sentence in XXX. However, despite the programming, you returned to your crime cycle and committed the serious index offences. (Detention 16)

In the fourth case however, the parole board member(s) articulated the sexual offending through a diagnostic lens. When I reviewed the decision in its entirety, there was a difference in the manner in which the parole board member(s) understood this offender's sexual behaviour compared to the other three cases:

> Your file contains multiple professional evaluations. Most of these assessments agree on an antisocial personality disorder and a substance abuse diagnosis. Most frequent other diagnoses have included *psychopathy*, paraphilia and narcissistic personality disorder. Mental health professionals, who have assessed your risk for sexual and violent reoffending with actuarial instruments (XXX), have all concluded that you present a high risk. In the last psychological assessment completed in professional estimates your probability for violence being high in the short, medium and long terms if you are community…You have also received psychological counselling and sexological treatment…It is difficult to determine whether or not these programs have had an impact in a carceral setting. Following your arrival at XXX, your CMT discussed with you the possibility of an inter-regional transfer for you to get involved in a specialized sex offender treatment in a psychiatric facility in a program where sex offenders was targeted nor did you accepted to participate. (DP/FP 25)

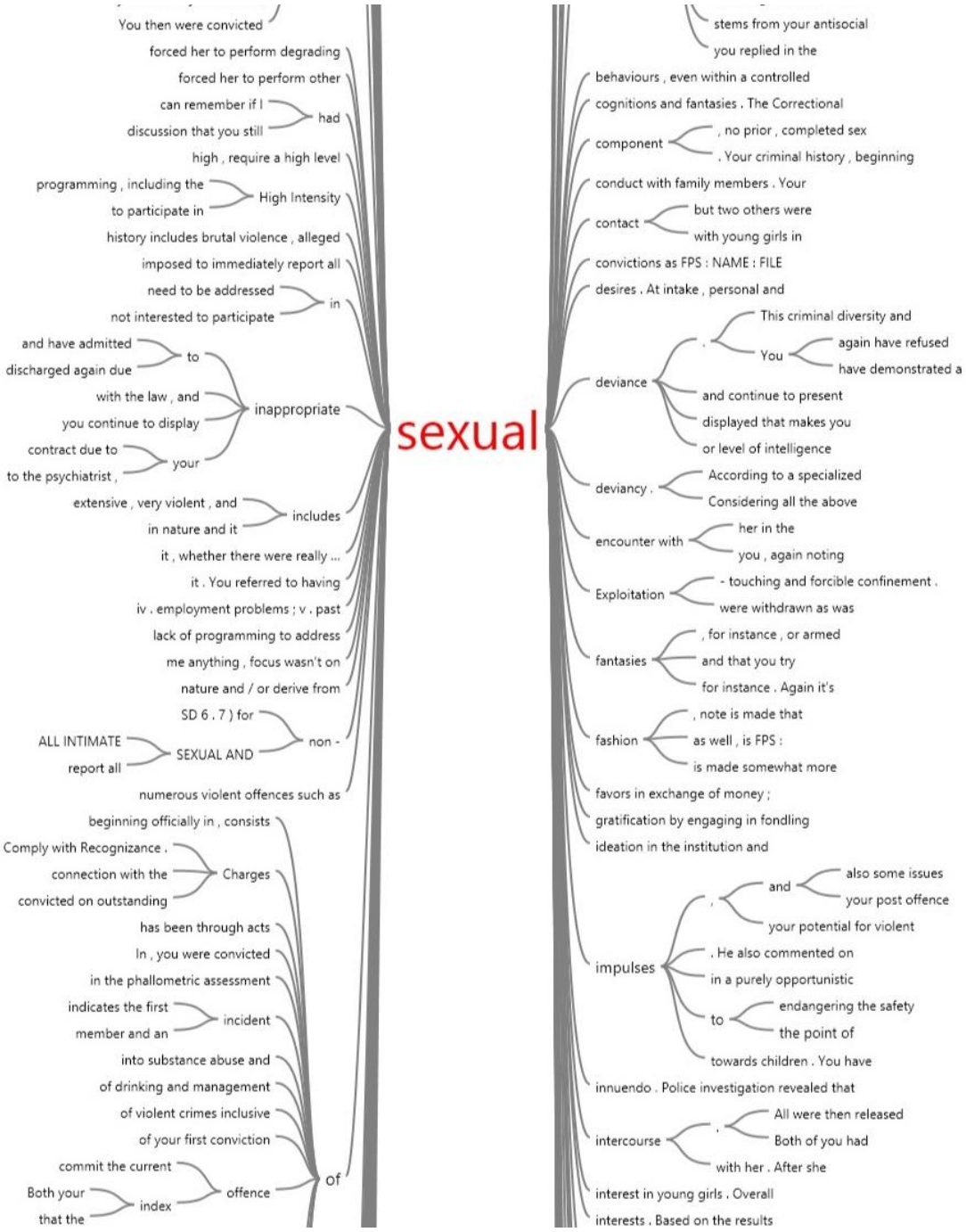
Especially when I consider the last outlier example, it would have been advantageous to access the background of the parole board members in these four cases from the decision registry in order to assess how the parole board member's individual *framing* of the information influenced their decision beyond this cursory document analysis. I suspect that in the last example, the parole board member's understanding of sexual deviance through a mental health lens differs according to the individual's personal understanding of mental health problems.

This micro-analysis of the decision rationale involving sexual offenders who were designated as Dangerous Offenders found that the psychological assessment on the offender had little influence in framing the sexual deviance as a mental health problem. In fact, three out of four teams of parole board members did not depict the sexual deviance as a mental health problem in their formal assessment for the decision registry. On broader terms however, this finding has significant implications for the psy professionals working in the correctional system in that the assessment was used as part of a decision-making process to label the offender as a risk subject.

7.7.1. Sexual Offending and Paraphilia

When I opened up the sample to include all sexual offenders in my data set, the distinction was much more profound. Out of 48 cases in the decision registry, in 17 hearings, and four interviews I was able to identify that 18 out of 48 of decisions from the registry were linked to sexual offences or sexual assaults. Five of the 17 hearings I observed made reference to sexual offence or sexual assault and one parole board member made reference to a sexual offender in the interview. The following is a diagram of a word tree of the key word "sexual" in an effort to understand how the word is used in context most often. The font size within the graph once again illustrates how often the words are used in relation to others words associated with the keyword "sexual":

Figure 2 – Word tree sub-section for "sexual"



Using the word tree, I found that the word "sexual" was used the majority of the time to construct concepts having to do with legal or deviance, i.e. depicting the male offender's criminal behaviours. The concept "sexual" was not necessarily linked with other concepts found in the

psychopathological model. This can be easily explained through the research that supports a risk based assessment of criminal conduct, and which also inform Canadian correctional policies.

Correctional research is concerned with risk factors associated with future offending because of the underlying assumption that "psychopathological perspectives perform very poorly when evaluated according to the standards of an adequate theory" (Andrews and Bonta 2010, 80). According to the authors:

> The best predictors match the Big Four theoretical factors: antisocial, associates, attitudes, personality, and also those described by PCCC theory as part of the Central Eight factors (e.g. family factors and social achievement indices such as education and employment). The poorest predictors were derived from the sociological and psychopathological perspectives. Thus, one important thing to be learned is that good offender assessment instruments result from the use of theories that guide us to selecting relevant variables for assessment (Andrews and Bonta 2010, 307).

Linked to the positivist conception of risk, PBC decision-making law and policy direct the parole board member to assess sexual deviance as a separate category from mental disorders. The following is a representation of a template of the various areas that the parole board member must take into consideration when assessing detention cases. Note that sexual impulses are a different category than the one that directs the parole board to assess mental disorders:

a. The Board is satisfied that you have shown a pattern of persistent violent behaviour established on the basis of the following evidence, in particular,
    1) The number of offences committed by you which caused physical or psychological harm
    2) Seriousness of the offence for which you are currently incarcerated
    3) Reliable information demonstrating that you have had difficulties controlling violent impulses or sexual impulses to be to the point of endangering the safety of any other person
    4) The use of a weapon in the commission of any of your offences
    5) Explicit threats of violence you have made
    6) Behaviour of a brutal nature associated with the commission of any offence
    7) Your degree of indifference as to the consequences to other persons
b. Reliable information about your sexual preferences indicating that you are likely to commit a sexual offence involving a child before the expiration of the offender's sentence according to law
c. Medical, Psychiatric or Psychological evidence of the likelihood of you committing such an offence owing to a physical or mental illness or disorder
d. Reliable information compelling the conclusion that you are planning to commit such an offence
e. The availability of supervision programs that would offer adequate protection to the public from the risk you might otherwise present until the expiration of your sentence according to law.

At times, parole board members wrote the template that they were using into their decision in the decision registry so I succinctly replicated this above for analysis; however, the *CCRA* s. 132 outlines a similar chart. The most compelling example of the influence of this template on the parole board member's decision-making related to sexual deviance through a legal or deviance logic, underscored in the following example from the detention decision registry. In this case, the parole board member draws on diagnostic information according to (b) of the above template to assess reliable information about sexual preferences and likelihood of committing a sexual offence; however in (c) the parole board member disqualifies the sexual deviance as a mental health problem:

> (b)…According to a specialized psychological report dated XXX you are assessed a very high risk to reoffend sexually. According to phallometric testing you have a preference for sexual activity with male and female children. Results also indicate that you have a preference for sexual activity with passive and coercive victims. Today you agreed that you are a pedophile.
>
> (c) Medical, Psychiatric or Psychological evidence of the likelihood of you committing such an offence owing to a physical or mental illness or disorder.
>
> There is no indication of physical or mental illness or disorder that would contribute to your sexual offending (Detention 17).

In order to ensure that I captured all aspects of sexual offending I ran the following word text queries to ascertain if any of these cases made reference to mental health diagnostic labels: 1) sexual disorder; 2) sexual paraphilia; 3) pedophile; 4) pedophilia; and 5) paraphilia. In all, I identified only three cases out of the 24 cases that were identified as sexually based offences that made references to "paraphilia" when discussing the offender's file. Two of the references were identified in the decision registry:

> According to the sexological assessment, you reported a preference for women between 17 and 29 years of age. For you, sex was apparently omnipresent and even obsessive and your relations with women focussed only on sex. You admitted a sexual attraction to teenage girls. The risk of reoffending was deemed moderate-high. The psychiatric assessment did not report symptoms of psychotic disorder or severe mood disorder and you were diagnosed with an antisocial and narcissistic personality disorder, an alcohol abuse problem, in addition to a history of attention deficit and hyperactivity disorder. No paraphilia was diagnosed. According to the psychiatrist, your inappropriate sexual behaviour stems from your antisocial and narcissistic personality, egocentrism, misogynous attitude, lack of empathy for women, and perception of women as sex objects. On three occasions, you refused to participate in the phallometric assessment of sexual interests. Based on the results of the Sorag and Static-99R, the risk of sexual recidivism was assessed as high. Upon your admission at the Regional Reception Center, you refused to complete the Computerized Mental Health Intake Screening. You also refused to participate in the phallometric assessment. (Detention 14)
>
> Your file contains multiple professional evaluations. Most of these assessments agree on an antisocial personality disorder and a substance abuse diagnosis. Most frequent other diagnoses have included *psychopathy*, paraphilia and narcissistic personality disorder…Mental health professionals, who have assessed your risk for sexual and violent reoffending with actuarial instrument, have all concluded that you present a high risk. (DP/FP 25)

The other reference was noted during a hearing that I observed. In this example, there was an exchange between the offender's assistant and the parole board member related to the offender's potential release plans. The following was transcribed as close to the actual conversation as I could capture. If there are quotations, it denotes that I was able secure the exact words used by the actor:

Assistant	He is 37 and he has a meal house of offending, needs to be helped with esteem, job, feeling attached, doesn't have friends, he needs therapy to address his paraphilia – perhaps he can treat it
PBM	"that's not what the research says"
Assistant	It is part of supervision: lawyer and parole board could brain storm
PBM	"not our mandate to brainstorm"
Assistant	"what about trying to keep the public safe? Treating the sex offending, COSA, NA, I am sure the therapy can help him, offending as much as he has, increase the insight
PBM	Addresses the offender: this is your "last kick at the can", an opportunity to tell the board the reasons you have cognitive distortions (Parole Hearing 1).

Overall I found that generally, parole board members construct the offenders' sexual offending as a particular type of legal and social problem or vice, one that places significant weight on the offender's insight into his own attitudes (i.e. cognitions) and tools such as medication and/or clinical dedication in order to overcome this problem.

7.7.2. Sexual Offending as Risk Factor

An offender's sexual preoccupation is understood in parole decision-making within the context of risk. Andrews and Bonta (2010) argue that a "promising approach to understanding sexual deviance is the assessment of the cognitions that support sexual deviance. [T]he importance of these cognitions and attitudes is that they represent dynamic risk factors or the criminogenic needs that are important for the supervision and treatment of offenders" (481). I have found that

parole board members characterize sexual desires/behaviours almost entirely through this framework, that is, as risk factors or criminogenic needs:

> Your risk to reoffend sexually remains unaddressed and therefore is assessed as high… You remain an untreated deviant sexual offender and it is essential that you begin to deal with your deviant sexual cognitions and fantasies. (DP/FP 1)

> The Board is of the opinion that your plan lacks structure and does not address your criminogenic factors. It is considered premature at this stage of your sentence. Furthermore, the Board believes that you must focus on the objectives set in your correctional plan and remain engaged in a long term process of change, as recommended in your latest psychological evaluation. Upon completion of its analysis, the Board concludes that any form of release is premature at this point of your sentence. You need to engage in your healing process in order to take more responsibility for your offences and to acquire the necessary tools to prevent and reduce the risk of relapse into substance abuse and of sexual recidivism. (DP/FP 19)

> Poor management of anger and impulsiveness, alcohol abuse which facilitates acting out with criminal sexual behaviour and a blatant lack of openness to intervention are the main risk factors to your criminality. You have significant needs in terms of drinking and management of sexual impulses, and also some issues in terms of spousal abuse and general violence. (Detention 4)

> The major dynamic risk factors requiring a high need for improvement were identified as personal/emotional orientation and attitude. You were assessed as a high risk for violence towards an intimate partner, a moderate risk towards others within the context of domestic violence and a high risk for sexual recidivism. The Moderate-Intensity Sex Offender Program was recommended and although you deny your current offences, you did participate in the Sex Offender Deniers Group. The final report dated notes some gains made and the program facilitator believes your risk for sexual reoffending has decreased, but to what specific degree could not be determined (Detention 8)

In fact, even in the few cases I note above where the parole board did construct the offender as having a mental health problem, the case was made to build this information into a risk logic. The following illustrates this finding:

	Sexual Deviance Mental Health Problem	Sexual Deviance as Risk Factor
DP/FP 25	Most frequent other diagnoses have included *psychopathy*, paraphilia and narcissistic personality disorder. Mental health professionals, who have assessed your risk for sexual and violent reoffending with actuarial instruments.	The main contributing factors related to your criminality are identified as substance abuse (alcohol and drug), personality disorder, sexual problem, great difficulty managing your emotions and impulses, cognitive distortions and need to control others
Detention 14	According to the sexological assessment, you reported a preference for women between 17 and 29 years of age. For you, sex was apparently omnipresent and even obsessive and your relations with women focussed only on sex. You admitted a sexual attraction to teenage girls. The risk of reoffending was deemed moderate-high. The psychiatric assessment did not report symptoms of psychotic disorder or severe mood disorder and you were diagnosed with an antisocial and narcissistic personality disorder, an alcohol abuse problem, in addition to a history of attention deficit and hyperactivity disorder. No paraphilia was diagnosed. According to the psychiatrist, your inappropriate sexual behaviour stems from your antisocial and narcissistic personality, egocentrism, misogynous attitude, lack of empathy for women, and perception of women as sex objects. On three occasions, you refused to participate in the phallometric assessment of sexual interests. Based on the results of the Sorag and Static-99R, the risk of sexual recidivism was assessed as high. Upon your admission at the Regional Reception Center, you refused to complete the Computerized Mental Health Intake Screening. You also refused to participate in the phallometric assessment.	Despite your participation in the high-intensity sex offender treatment program of for nearly your entire sentence, you seem to have been unable to make any progress against your risk factors. Your statements in meetings were detached, self- absolving, and sometimes even phantasmic.

Parole Hearing 1	**Assistant** He is 37 and he has a meal house of offending, needs to be helped with esteem, job, feeling attached, doesn't have friends, He needs therapy to address his paraphilia –perhaps he can treat it. **PBM** Not what the research says…	Exchange between the Parole Officer and Parole Board members discuss that the offender serving time for sexual assault and controlled substance, completed the high risk sexual program, notes that he is a high actuarial risk, made some progress in the program but couldn't implement these changes, still engages in risk cycle, gains have been made in a controlled institution

Note that in DP/FP 25, the risk factors identified could also be constructed through a mental health lens; however, the parole board member goes on to make a categorical distinction between the diagnosis of paraphilia from the risk of "sexual problem". Overall, I found that even when parole board members reviewed psychological information related to the offender's sexual deviance, the assessment had little influence depicting sexual deviance through a therapeutic frame. Instead, organizational templates and legislation frame sexual deviance as a risk factor and as such, parole board member are directed to understand sexual deviance through this lens. This does not suggest that parole board members see mental health problems and risk factors as dichotomous categories. Rather, parole board members re-interpret the data into a language that is malleable for a risk based analysis. In this way, parole board members appropriate psychological concepts from the diagnostic field such as pedophilia, and phallometric testing and then reconceptualise and substantiate sexual deviance as a risk factor. Yet, they use diagnostic labels in justifying assessments of elevated risk.

7.8. SUBSTANCE ABUSE AND MENTAL HEALTH PROBLEMS

The following quote highlights the ambiguity often attached to the conceptualizations of mental health disorders:

> The issue is confused by the use of the term 'mental illness' sometimes to mean only the serious psychotic disorders, including schizophrenia, and at other times to include all of the various conditions listed in the DSM-IV, including antisocial personality disorder and substance abuse (Macphail and Verdun-Jones 2013, 1).

Disorders associated with substance abuse were identified in early DSM publications under the category of disorders of alcoholism. Later versions divide alcoholism into two different categories: substance dependence and substance abuse[71] and combines alcohol with other related substance abuse disorders. The most recent DSM-5 has since combined these diagnostic categories into one, substance disorder, which is located in the Substance abuse and addictions chapter of the DSM. Substance dependence can be measured on a continuum from severe to mild. Substance dependence is separated from other syndromes related to addictions such as gambling addiction (APA 2015).[72]

Despite the inclusion of substance dependence in the DSM-5, there is significant controversy related to substance abuse as a mental health problem. This controversy has a long history. Conrad and Schneider (1982) analysed this lengthy and political debate on substance abuse (alcohol and opiates) as a mental illness. For these authors, the crux of the issue is not necessarily that the diagnostic category is contested, but rather they focus on how these constructs have been linked to the medical model and deviance. According to them, although there are physical withdrawal symptoms that are managed through a medical response, substance use and abuse as a mental health problem remains a political issue. (77).

Conrad and Schneider (1982) identify the two sides of the controversy. On the one hand, there is the disinhibitor hypothesis, where the effects of alcohol are considered to be universal. Alternatively, there is a perspective referred to as the disease concept. This latter perspective has gained popularity through the rise of what has been termed "the therapeutic state" (Conrad and

[71] http://pubs.niaaa.nih.gov/publications/arh27-1/5-17.htm (March 19, 2015)

[72] http://www.dsm5.org/Documents/Substance%20Use%20Disorder%20Fact%20Sheet.pdf

Schnieder 1982). Evidence for the therapeutic state is found in various sources; government funded construction of the Yale research centre to empirically study addiction as a disease, the creation of the AA self-help model that considers alcoholism a disease, and medical support for the notion that substance abuse is a disease that requires clinical management by healthcare professionals.

My decision to include or not to include substance abuse as a mental health problem for this study was a complex one. In the end however, my reason was to include substance abuse as a construct for analysis along with other mental health problems. Disregarding this construct when studying mental health problems would be likened to ignoring the elephant in the room. We know that many theorists and mental health professionals hold that substance abuse is a mental health problem. Hence, the omission would be glaring and arbitrary. Moreover, since my research questions are related to how parole board members operationalize mental health problems, not how I may or may not define substance abuse. Therefore, it is best to include substance abuse within the data as a factor to examine to answer my research question(s).

7.8.1. Substance Abuse as a Mental Health Problem

The prevalence of substance abuse issues in the correctional setting is important to summarize, as 80% of all offenders are identified with substance abuse problems[73], which amounts to three out of four offenders entering the system[74]. In my research, I had expected that parole board members would draw on references to mental health problems readily from the case management documents, especially disorders reported in psychological reports. Since all detention cases require a psychological risk assessment in order for the parole board member to render a

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[73] http://www.parl.gc.ca/content/hoc/committee/403/secu/reports/rp4864852/securp04/securp04-e.pdf (March 26, 2015)

[74] http://www.publicsafety.gc.ca/cnt/cntrng-crm/crrctns/sbstnc-bs-eng.aspx (March 26, 2015)

decision, I anticipated that detention cases would have a higher rate of reference to mental health problems compared to other types of parole releases that may not review a psychological risk assessment for decision-making purposes. Moreover, given the high rate of substance abuse problems in the offender population, I suspected to see more references to substance disorders within the detention cases.

As noted above, the DSM has historically identified substance abuse through two different classificatory labels: substance dependence disorder and substance abuse disorder. Therefore, when I did a content analysis of substance abuse as a disorder I searched both classificatory labels. Recall that my research consisted of 48 decisions from the decision registry, 17 transcripts from observation of parole hearings, and four interviews for a total of 70 cases for analysis. Overall, there were four references to substance related mental disorders as per the DSM classification system, all from the parole decision registry:

> File information reports that you were diagnosed with Bipolar Disorder in XXX, as well as Depression with Psychiatric symptoms, antisocial personality traits and poly-substance abuse. (Detention 1)
>
> "The court ordered Forensic Assessment determined you did not appear to suffer from any acute mental disturbances at that time. Your primary diagnosis was poly-substance dependence (alcohol, crack cocaine and marijuana)." (Detention 5)
>
> "Assessments agree on an antisocial personality disorder and a substance abuse diagnosis. Most frequent other diagnoses have included *psychopathy*, paraphilia and narcissistic personality." (Day/Full Parole 25)
>
> "Another Psychiatric Assessment from October, after a month long assessment, diagnosed a history of major depression disorder - in remission; a history of dysthymia - in remission and a history of substance induced mood disorder - in remission." (Day/Full Parole 20)

One other diagnostic type of reference should be noted:

> "In a psychological assessment conducted in XXX, the specialist made the following diagnosis impressions: sensitivity to a dependence on intoxicants, generalized anxiety

> disorder, traits of obsessive/compulsive disorder and antisocial personality with underlying narcissistic traits." (Detention 9)

In all these cases, the substance abuse diagnosis was referenced alongside other mental disorders as noted by "experts" in mental health. I was initially surprised by the low incidence of references to substance abuse diagnosis given the extent of the substance abuse problems in the offender population in Canada. However, when I analyzed the data according to the term substance abuse it became obvious that substance abuse was referenced a great deal, as parole board members drew on substance abuse problems through a risk discourse.

7.8.2. Substance Abuse as Risk Factor

Parole board members appear to understand that the primary construction of substance abuse is risk-related in nature. It is pragmatic, not disease-based (ontological). There are two sources of support for this statement. First, during my fieldwork as a participant observer, I was afforded the opportunity at the end of each day to engage in informal conversations with various parole board members. In every circumstance, I was asked about the focus of my research. During these discussions, I queried the inclusion of substance abuse as a component of mental health problems. Out of the seven days of informal discussion that included seven sets of parole board members, five sets of parole board members clarified that they did not understand substance abuse as a mental health problem but rather a risk factor. On one occasion, the parole board member further articulated that for the purposes of parole decisions, he/she viewed substance abuse strictly as a risk factor. However, he/she understood addiction issues associated with one of his/her family members as a mental health problem. This is a good illustration of how organizational factors influence parole board members understanding of the primary construct of substance abuse. The parole board member articulated his/her cognitive dissonance, explaining why he holds conflicting

representations of substance abuse, one through a risk related construct and the other through the disease model.

In order to understand substance abuse as a risk factor, we must return to Bonta and Andrews (2006) seminal work on risk and recidivism. In Canadian correctional policy, risk is determined through actuarial assessments that conceptualize the offender as a risk subject (see Andrews and Bonta 2006; Andrews, Bonta, and Wormith 2006). According to Bonta and Andrews:

> Risk factors refer to characteristics of people and their circumstances that are associated with an increased chance of future criminal activity. For example, favourable attitudes toward crime are linked with increased chances of criminal behaviour compared to mixed ["so-so"] attitudes towards crime. The clinical [or practical] applications of risk factors are many. In correctional agencies and facilities and in forensic mental health settings, issues of risk of reoffending are crucial to decisions of early release (e.g. parole or discharge), level of supervision in community supervision programs, and level of custody in the classification of prisoners (2006, 20).

Within this framework, substance abuse is one of the central eight risk factors that are identified as contributing to recidivism. The following graph represents the other risk factors associated with criminal recidivism:

Table 7 - Criminal Risk Factors[75]

	Factor	Risk
The "Central Eight" Risk Factors	Family and/or marital	Two key elements are nurturance and/or caring and monitoring and/or supervision.
	School and/or work	Low levels of performance and satisfactions in school and/or work
	Leisure and/or recreation	Low levels of involvement and satisfaction in anticriminal leisure pursuits
	Antisocial cognition	Attitudes, values, beliefs, and rationalizations supportive of crime; cognitive emotional states of anger, resentment, and defiance; criminal versus reformed identity; criminal versus anticriminal identity
	Antisocial associates	Close association with criminal others and relative isolation from anticriminal others; immediate social support for crime
	Antisocial personality pattern	Adventurous pleasure seeking, alienation, restlessly aggressive
	History of antisocial behavior	Early and continuing involvement in a number and variety of antisocial acts in a variety of settings
	Substance abuse	Abuse of alcohol and/or other drugs
Examples of Minor Risk Factors	Major mental disorder	
	Physical health issues	
	Seriousness of current offence	

As noted above, when I analyzed the data with regard to substance abuse as a mental disorder five references were found. However, when I analyzed the term substance abuse in its original context, 27 of the 48 parole decisions cases and five of the 17 parole hearings made reference(s) to substance abuse. Of these 32 cases, 28 referenced substance abuse in the context of risk (i.e. depicting substance abuse as a risk factor). The following example highlights this contextual link:

[75] Andrews, Bonta and Wormith 2006.

> However, you do not acknowledge a problem with substance abuse, nor do you link such a problem with the commission of your offences. With these elements, the Board can only conclude that you do not present observable changes or any understanding of your contributing factors; and consequently, that you remain an untreated offender presenting a high risk of violent and/or sexual recidivism. (Parole Detention Decision 4)

Three of the cases made reference to substance abuse only within the context of treatment/programming:

> You have had the benefit of programming and treatment over the course of incarceration. You completed the following interventions; Wellspring Sex Offender Program in XXX the National Substance Abuse Program Moderate Intensity in XXX, National Substance Abuse Pre-Release Booster in XXX the Long Term (42 day) Substance Abuse Treatment Program. (Parole Detention Decision 10)

Overall, 14 of the 32 cases referenced substance abuse both as a risk factor and in context to treatment or programming. One case understood how substance abuse was a risk construct by drawing on the mental health problem. This is not necessarily surprising. Canadian correctional policy is informed by risk based logic, which is determined through a combination of actuarial or statistical tools along with clinical judgement. In Canada, this risk-based logic is referred to as Risk Management Model (RMM). The effectiveness of the model rests upon the assumption that actuarial tools promote an informed objective assessment process (Smith, Cullen and Latessa 2009)[76]. Simply stated, substance abuse as a mental health problem does not fit into this RMM framework. Risk scholars themselves make reference to the irrelevance of whether substance abuse is a mental health problem or not, "[i]n regard to substance abuse as mental illness, we expect there was an alcohol-crime link long before alcoholism came to be viewed as a disease, and diagnosed or not, the alcohol-

[76] This commitment to an empirical based risk framework was further reinforced by the promulgation of the Corrections and Conditional Release Act (CCRA) in 1992 that identified the overarching goal of risk and public safety. In effect, the RMM was prescriptive in its implementation of the classification of risk, some have argued to the detriment of rehabilitation (Berard, Vecheret, and Lemire 2013). In this way, the RMM has the capacity to achieve the risk objectives outlined in the legislation by conceptualizing the offender as representing a "real" (as opposed to a perceived) risk through the various tools that make empirical claims to risk assessment.

crime link exists" (Bonta and Andrews 2006, 83). This quote highlights the influence of the organization to hyper focus certain criteria as a risk, therefore reconstructing this complex social problem, (i.e. substance abuse) away from a discussion about the factors that contributed to the substance abuse "problem" in the first place. This is similar to the findings noted in the previous section on sexual deviance. However, unlike the findings presented in the sexual deviance chapter, but in keeping with the RMM model, I found that parole board members do not draw on diagnostic labels in their construction of substance abuse in their decisions.

7.9. PSYCHOPATHY AS A MENTAL HEALTH PROBLEM

Psychopathy is a term that describes a set of character traits commonly associated with the forensic population. The term was first introduced by Ceckley (1941) who depicted the psychopath through various characteristics or traits. His work was further developed by Hare (1985, 1991, 2003) through the creation of the PCL-R; a checklist type tool developed to measure characteristics associated with psychopathy. Since that time, although not developed originally for such a purpose, the term has come to be used predominantly with forensic populations in a risk prediction paradigm.

While not identified by recent DSM publications as a mental disorder, psychopathy is a construct that shares many commonalities with the diagnosis of anti-social personality disorder (ASPD). Some theorists have argued for the consideration of psychopathy as a subsection of the disorder, going so far as to claim that one in five people with ASPD also meet the more restrictive criteria to be considered a psychopath (Kiehl and Buckholtz 2010). Hare (1998) argues that the difference between the two is linked to the emotional-interpersonal dimension. Overall however, ASPD and psychopathy rely on two different diagnostic systems, the former is linked to the DSM-5 (and its predecessors: DSM-IV-R, DSM-IV, and DSM-III) whereas the PCL-R is the tool used in the determination of psychopathy.

Assessment of psychopathy using the PCL-R relies on twenty predetermined traits and assesses these traits on a 0-2 point scale. The score determines whether or not the person meets the criteria for the diagnosis of psychopathy. The following is a list of the twenty traits used in an assessment with the PCL-R:

- glib and superficial charm
- grandiose (exaggeratedly high) estimation of self
- need for stimulation
- pathological lying
- cunning and manipulativeness
- lack of remorse or guilt
- shallow affect (superficial emotional responsiveness)
- callousness and lack of empathy
- parasitic lifestyle
- poor behavioral controls
- sexual promiscuity
- early behavior problems
- lack of realistic long-term goals
- impulsivity
- irresponsibility
- failure to accept responsibility for own actions
- many short-term marital relationships
- juvenile delinquency
- revocation of conditional release
- criminal versatility

(Hare 2003).

These items can be divided into two primary factors. The factor one characteristics generally refers to the individual's personality, while factor two characteristics generally refers to behavioral or antisocial inclinations. Along with a review of the checklist, the evaluation also includes an assessment of other factors of the subject's background, which includes their work and educational history, marital and family status, and criminal background. The tool is administered by a qualified technician, who assigns 0, 1 or 2 to each criterion, thus rendering a total score of 0-40. A score of 30 or above is suggestive of the presence of psychopathy. In comparison, an offender considered to be non-psychopathic would often fall within the 20-22 range.

Research over the past decade provides evidence within the risk literature to support the predictive value of the PCL-R for violent recidivism (Skeem and Mulvey 2001; Salekin, Roger, and Sewell 1996), general criminal recidivism (Salekin, Roger, and Sewell 1996; DeMatteo, Edens and Hart 2010; Singh, Grann, and Fazel 2011; Yang, Wong, and Coid 2010; Gendreau, Little and Goggin 1996), sexual recidivism (Hawes, Boccaccini, and Murrie 2013), institutional misconduct (Guy et al 2005), and treatment responsiveness (Skeem, Monahan, and Mulvey 2002).

However, this body of research on psychopathy is plagued with inconsistencies and/or subject to much debate (Andrews and Bonta 2006, 259; D'Silva, Duggan, and McCarthy 2004). One area of debate involves the PCL-R's true predictive utility. According to a few studies, the PCL-R is not predictive among some forensic populations (Guy et al. 2005; Leistico et al 2008). Others have argued that the PCL-R is not superior to other available risk assessment tools such as the Level of Service Inventory-Revised, LSI-R (Hemhill, Hare, and Wong 1998; Gendreau, Goggin, and Smith 2002) or the Lifestyle Criminality Screening Form –LCSF (Walters 2003). Some have argued that the tool's predictive value lies in the results of the factor two characteristics, which are empirically linked

with violent recidivism (Kennealy et al 2010). Others have advanced the multidimensional nature of the tool (Lynam and Miller 2012; Salekin et al 2006; Hawes, Boccacini, and Murrie 2013; Walters and Heibrun 2010). In a review of how professionals engage with the tool for the purpose of legal decisions, Dematteo et al (2014) identified an issue with regard to how professionals have misinterpreted the results of the PCL-R for predictive purposes:

> In multiple cases, PCL-R percentile ranks seemed to be equated with violence risk. In one instance, for example, because an offender received a score of 31, he was described as being more dangerous than 92 of every 100 inmates (*People v. Galindo*, 2007). In another case (*In re Calderon*, 2010), a potential parolee's low PCL-R score was described as indicating that he had a lower potential for violence than 96% of North American male offenders. Of note, none of these troubling statements regarding risk resulted in admissibility challenges or successful appeals. (Dematteo et al 2014, 102)

As the authors explain, because the tool is rarely challenged in legal contexts, the consequences of misapplication or misunderstood results can have a significant impact on how the person is labelled or categorized.

Another debate related to the application of the tool is focused at the level of theoretical conceptualization. Skeem and Cooke (2010) for example, argue that the criminality measure (one of the items on the list of assessment is delinquency) is conflated within the PCL-R. Moreover, the authors argue that a theoretical link is required to substantiate the inclusion of criminality as a key descriptive feature. In their opinion, criminal behaviour should be understood as a correlate of psychopathy and criteria within the tool itself (2010, 440).

These debates around the use of the tool are not likely to subside given the significant increase in the use of the PCL-R in criminal justice proceedings such as courts, sentencing, and correctional decisions to inform risk related assessments. Scholars working in this area, for example, found that prosecutors relied on the tool in their depiction of the accused significantly more than the defence (Dematteo and Edens 2006; Dematteo et al 2014). In fact, these authors refer to the PCL-R as the

"prosecutor's tool", arguing that more study examining the impact of the tool as applied to the legal system needs to be completed.

With regard to the use of the PCL-R, DeMatteo et al (2014) found an increased use of the tool over the years, rising from 87 cases during 1991-2004 (13 years) to 348 cases during 2005-2011 (6 years) (DeMatteo and Edens 2006; DeMatteo et al 2014). They observed an influential increase in the use of the PCL-R during parole decisions and recommended that further study should be directed towards the weight given to the PCL-R in release decision-making. When one considers the growth in the use of the tool for prosecutors, as well as the sheer increase in the use of the tool across the legal system, it is apparent that the PCL-R is having a profound effect upon decision-making within the legal system.

I had not expected to be analyzing data related to psychopathy, or the PCL-R within a dissertation focusing on mental health. However, I could not ignore its presence within the data. For example, after I had analyzed the decision registry data and attended numerous hearings I noticed that there was a difference in the way parole board members drew on the PCL-R compared to how they used the construct of psychopathy. Namely, that the tool and the construct were identified by parole board members with other 1) actuarial tools; and 2) mental health labels, i.e. personality disorders. This section therefore, is the result of my analysis of the PCL-R and the term psychopathy.

7.9.1. PCL-R and Actuarial Tools

Consistent with Dematteo et al findings (2014), the current found that when the PCL-R was mentioned in the parole registry decisions, it was always referenced alongside other actuarial data. For example, the PCL-R was identified in four out of 23 detention cases and one out of 25 day/full parole cases. The PCL-R is also used as a measure within other risk assessment tools within the

decision registry. For example, the VRAG is a violent risk assessment tool that draws on the PCL-R as part of its scoring. In my sample, the VRAG was referenced five times within the detention cases and once in the day/full parole cases.

The difference between the two decision types in numbers of times referenced can be partially understood if we consider that PBC requires that a psychological risk assessment be completed. As per the PBC's *Decision-Making Policy Manual* 2.2*:*

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5. A psychological risk assessment is required for a review involving:
   a. persistent violence, as demonstrated by three or more Schedule I offences, which occurred on different days, where each conviction led to a sentence of at least six months duration;
   b. gratuitous violence, as demonstrated by excessive violence beyond that which is "required" to meet an end, or evidence of sadistic behavior or torture;
   c. a detention referral;
   d. conditional release for an offender with an indeterminate or life sentence; and
   e. a high risk sex offender. This may be in the form of a specialized sex offender assessment.

Actuarial tools are a component within a psychological risk assessment. I found only two of the 23 detention cases that did not make any reference to actuarial data. This absence is explained because these offenders did not consent to the psychological assessment process. For DP/FP parole hearings, a psychological assessment is not necessarily required for a parole review unless the offender meets the requirements listed above. Therefore, unless there is a need for a specialized assessment that would involve administration of the PCL-R, parole board members may only be provided the results of routine actuarial tools such as the LSI-R or the SIR scale, which are tools that are used within the case management process.

Also consistent with DeMatteo et al (2014) study, I found that references to the PCL-R always involved the context of risk statements about recidivism in the formal decisions. For example:

> "our most recent psychological risk assessment dated XXX, confirms that you are not suitable for any type of community release at this time. The report indicates that you scored at approximately the 99th percentile based on your total PCL-R score. Your total score results indicate a very high correspondence with the psychopathic features of a prototypical psychopath and that you are a high risk for both violent and non-violent recidivism." (Day/Full Parole Decision 12)

> "A psychological intake assessment used the following actuarial measures to predict risk to reoffend: Statistical Information on Recidivism scale (SIR), Self Appraisal Questionnaire (SAQ), Level of Supervision Inventory (LSI-R), *Psychopathy* checklist (PCL-R), and the Risk Appraisal Guide (VRAG). Based on the psychologist's clinical observations and the results of the administered measures, you present as a high risk for violent and non-violent recidivism." (Detention Decision 13)

> "A psychological risk assessment utilized the Hare *Psychopathy* Checklist - Revised (PCL-R), where you scored in the moderate range, and the Violence Risk Appraisal Guide (VRAG), where you scored in the medium to high range for violent recidivism. The psychologist concluded that you have not addressed your risk and could be considered as a medium to high risk for reoffending both violently and non-violently." (Detention Decision 19)

> "A special Sex Offender Assessment completed in XXX used the following risk assessment tools to assessed risk of recidivism: Static 99, Stable 2007, Hare *Psychopathy* Checklist-Revised (PCL-R), and the Violent Risk Appraisal Guide (VRAG). Risk for sexual recidivism is assessed as very high, require a high level Sexual Offender Program." (Detention Decision 20)

> "A psychological risk assessment completed in XXX noted some minor positive changes. Utilizing the Static-your score placed you in the Moderate-Low risk category. Your score on the STABLE-2007 resulted in a high needs classification. Combining both scores, you were identified as a moderate-high risk for sexual and violent recidivism. Using the *Psychopathy* Checklist - Revised (PCL-R), your overall score identified you a high risk for violent recidivism. The Sex Offender Risk Appraisal Guide (SCRAG) also found you a high risk to sexually reoffend." (Detention Decision 23)

In these cases, the parole board member draws on the expert's actuarial assessment of the PCL-R, lending to a powerful construction of the offender as a risk subject based on their score of psychopathy[77]. Similarly, the construct of psychopathy was also referenced related to risk statements during the interviews with former board members.

In the interviews however, former parole board members did not make reference to the PCL-R, instead constructing the offender through the diagnostic of psychopath or psychopathy directly:

> *The rule of thumb was that about ten percent of the prison population would never be released simply because their risk factors were so great. So, yes, we would have violent offenders who are, you know, who are identified as psychopaths. And the recommendations would consistently be that the risk is simply too high. And they would recommend that we would deny parole. (Interview B)*

In another example from the interviews, the former parole board member was asked to speak to the construct of psychopathy directly and does so in the context of risk statements:

> *Ok, so, that's a very… that's a real challenge, so you get people with a label of psychopathy, psychopathic behavior, et cetera, and it's theoretically untreatable… and so it's still a matter of assessing their risk against the kinds of tools that you have available to you as a parole board member to mitigate that risk…and frankly, it didn't come up very much in my tenure as a parole board member, but I did find it in reviewing files where that label was present in the file, is that you needed a lot more information, and again it wasn't just about this person's been diagnosed as a psychopath so therefore, so there wasn't… therefore, it wasn't automatic. (Interview A)*

Overall, the PCL-R and the construct of psychopathy are used in the process of risk assessments, both in their construction of risk statements and in the case of the PCL-R, in their

[77] As a side note, the parole board members often refer to more than one actuarial tool in this section despite direction by the structured framework guide that underscores that the use of more than one risk element does not equal a better prediction. As stated in the Chapter Two within the structured framework section, the first step in the risk assessment process is to determine the actuarial risk level. Board members are reminded of the instruments that provide the greater predictive values, i.e. SIR-R or LSI-R.

actuarial form. The psy professional plays an integral role in this process. This supports previous research making the same claims.

7.9.2. Psychopathy as a Mental Health Problem

As noted above, the PCL-R is a tool used in the identification of characteristics associated with psychopathy, similar to how the DSM is a tool used in the identification and classification of various mental disorders. Psychopathy is not a bona fide mental disorder as per the DSM. However, a review of the decision registry, interviews, and hearings in this study suggest that parole board members do not necessarily make this distinction.

My interviews served as an opportunity to explore how parole board members understand the construct of psychopathy. One key observation is that informally parole board members do not generally reference the more technical risk assessment tool (i.e. PCL-R) in their informal discussion of psychopathy or psychopath. In one interview while discussing mental health, a former parole board member raised the construct of psychopathy independently of being prompted, so I asked if he/she thought it was a mental health problem:

> *I think that, when I say mental health I'm talking about everybody, I'm not talking about people diagnosed with psychiatric problems only, so all of us have mental health, it's just, you know, people that are normal people or considered "normal people" we all have mental health, and sometimes our mental health is less well than other times depending on the stresses and factors that… going on in our lives. And then you go further along the continuum and you get people that actually have just more difficulty coping, people that have psychiatric diagnoses, and then people that have psychopathic characteristics. Whether that is a health issue or not, that is not up to me to say and I don't think that I would even, you know, think that I could say whether that is a mental health issue or not. As far as a psychiatric issue, I don't know, is it in the DSM? (Interview D)*

After analysing the decision registry for content in its raw presentation, I note that when psychopathy was raised independently by parole board members, they clearly reference psychopathy with other mental health problems. For example, see decision (25):

> Your file contains multiple professional evaluations. Most of these assessments agree on an antisocial personality disorder and a substance abuse diagnosis. Most frequent other diagnoses have included *psychopathy*, paraphilia and narcissistic personality disorder. (Decision 25)

I note that the parole hearings reference the diagnostic label psychopath in the hearings:

> "…you are extremely dangerous, your behavior is irregular, you are personality disordered, limited cognitive ability, severe character deficiency, psychopath, schizoid…" (Hearing 17)

This linkage could be explained simply by reviewing its documented location on the structured decisions, namely that they are directed to present the construct alongside other mental disorders as discussed above (Serin 2011). At a basic level, this explanation provides context as to why board members and former board members frame it as a mental health construct. It is framed as a diagnostic. One could argue that it is irrelevant whether psychopathy is understood as a mental health problem. I would argue otherwise, that it is important. First, the primary purpose of this research is to understand how parole board members operationalize mental health problems in parole decisions. While psychopathy is not classified as a mental disorder, this study suggests that at the very least, parole board members frame it as a general mental health problem.

Second, being identified as a psychopath, or disordered for that matter, has significant implications for criminalized populations, i.e. offenders. The label in and of itself creates new forms of control that decision makers draw upon in the decision-making process (Christie 1993; Cohen 1985). For example, as discussed in the section on self-regulation, when an offender is diagnosed as *Bipolar* or with *Depression*, parole board members analyze whether or not the offender is managing that mental health problem. However, it is unknown how to treat or change the characteristics associated with psychopathy (Andrews and Bonta 2010; Reid and Gacono 2000). Thus, being labelled as a psychopath has obvious implications for decision-making if this construct is understood to be unmanageable or untreatable. For example, during one interview a former board member

noted, "*so you get people with a label of psychopathy, psychopathic behavior, et cetera, and it's theoretically untreatable…"* (Interview A). Moreover, referencing psychopathy was used with a negative connotation, like an aggravating factor during two hearings:

> "You used threat of violence, instrumentally, it suggests that clearly you want to change. You have two options, either you are a psychopath or want to change, no one saying you are a psychopath so obviously you want to change"

In the other hearing:

> "you are extremely dangerous, your behavior is irregular, you are personality disordered, limited cognitive ability, severe character deficiency, psychopath, schizoid…" (Hearing 17)

In these examples, being open to change one's behaviour is presented as the alternative to being a psychopath. The inference is that psychopaths cannot change their being. In the other, being a psychopath is associated with erratic and dangerousness, having a flawed personality.

It is useful to draw on *risk discourses* here and their powerful role in labelling the population as responsible and/or accountable vs. unmanageable and/or untreatable. I discussed earlier in this chapter that parole board members draw on mental health and problems with mental health and its relation to medication and treatment compliance. In the following example from the decision registry, the offender is noted to have taken corrective measures to manage his depression:

> You have developed alternate strategies to deal with such things as social isolation, anger, and depression and you provided examples of some of those strategies to the Board. You identified feelings of isolation as your primary risk factor. You said that you are currently managing any symptoms of depression and you utilize various strategies to deal with it on an ongoing basis. (DP FP 20)

On the contrary, the *risk discourses* related to the criminal psychopath characterize the offender as flawed, untreatable, and/or unmanageable. The following is an example taken from former parole board members as they engage with the narrative of the "psychopath" as untreatable:

> *Ok, so, that's a very… that's a real challenge, so you get people with a label of psychopathy, psychopathic behavior, et cetera, and it's theoretically untreatable… and so it's still a matter of assessing their risk against the kinds of tools that you have available to you as a parole board member to mitigate that risk… and frankly, it didn't come up very much in my tenure as a parole board member, but I did find it in reviewing files where that label was present in the file, is that you needed a lot more information, and again it wasn't just about this person's been diagnosed as a psychopath so therefore, so there wasn't… therefore, it wasn't automatic. (Interview A)*

> *The rule of thumb was that about ten percent of the prison population would never be released simply because their risk factors were so great. So, yes, we would have violent offenders who are, you know, who are identified as psychopaths. And the recommendations would consistently be that the risk is simply too high. And they would recommend that we would deny parole. (Interview B)*

In sum, contrary to the other three sections in this chapter, psychopathy is a construct that is not necessarily part of the official psychiatric nomenclature, yet it is generally understood by parole board members as one. Although the sample size is limited here, the implications of this finding are significant. This will be discussed in the following chapter.

7.10. CONCLUSIONS

Overall, this section has explored how mental health problems, specifically mental disorders as defined by the DSM-5, were represented in parole decisions. I found compelling differences between how parole board members draw on various mental disorders and I have described the similarities and differences in the means by which each diagnostic label influences decision-making: gambling addictions, sexual deviance, substance abuse disorders, and *psychopathy*. The two sections of this chapter help to expand upon the existing literature on parole decision-making and mental health problems. In the first section, I present two key assertions: the mere presence of a mental disorder does not negatively influence the parole decision-making process but rather it is 1) the <u>presumed nature</u> of mental health problem (treatable versus untreatable); 2) whether the offender complies with treatment for the mental health problem. In the second section of this chapter I found

interesting differences in the way gambling was understood and conceptualized by the parole board member, dependent upon input from the expert. I found that both substance abuse and sexual deviance are constructed as risk factors in decision-making and the construction of these problems in behaviours are not necessarily understood as mental health problems. However, I underscore that although parole board members do not conceptualize sexual deviance as a mental health problem, they do draw on diagnostic labels (i.e. pedophilia, paraphilia) when depicting the risk associated with the sexual deviance. This section also found that the concept of psychopathy while not identified as a mental disorder, might be understood as one. Overall, these findings have significant implications if we consider another key finding of this chapter: the offender's ability to manage or regulate his mental health problems, whether through treatment or medication, is very influential to the decision-making process. Most striking, the last finding suggests that parole board members do not define mental health problems as per the DSM-5. This has considerable practical and ethical implications if we consider the larger socio-political context that aims to recognize and respond to the needs of offenders with mental health problems. Perhaps the most obvious being the re-conceptualization of mental health problems to risk factors.

Chapter 8. Theoretical Contribution

The last chapter emphasized the role of the expert in the determination of mental health problems within the decision-making process. In that discussion, I examined how parole board members draw on expert assessment as the main source to ascertain the presence of a mental health problem, namely relying upon diagnostic information found in the DSM-5. I also observed that diagnostic information is reviewed with an eye towards whether the offender has successfully regulated the behaviours associated with their mental health problem(s). I discussed the role of compliance with a medication regime in the regulation of certain mental health problems. The second part of chapter 7 examined how parole board members understand mental disorders as per the DSM-5, as referenced within the data set.

In this chapter, I situate the key themes identified in observations of my data within Hawkins' (1986) conceptual decision-making framework, linked to symbolic interactionism. An interactionist analysis alone, however, does not provide an adequate explanation for the ways systems of thought or organizational structures have influenced individual actors (Hacking 2004). Therefore, I supplement this analysis with concepts from the governmentality literature in order to build upon an interactionist framework to better capture how parole board members understand or give meaning to phenomena through their interaction with others and institutional structures.

8.1. HAWKINS' CONCEPTUAL FRAMEWORK

In my earlier theoretical chapter, I detailed Hawkin's conceptual framework. I argued that his model is useful for understanding the decision-making process linked to three organizing concepts:

the *surround;* the *decision-making field;* and the *frame*. In this chapter, I will map out the parameters of this conceptual model to help explain my findings. This will be achieved by examining the following:

- Provide a theoretical explanation for the alignment of diagnostic information with actuarial scores by linking file information with case-management risk rationality within the *surround*;
- Discuss how responsibilization strategies used within the *surround* are linked to the context of neo-liberal risk logic;
- Articulate how the role of the expert is implicated in responsibilization strategies and risk discourse;
- Trace the influence of the CCRA, the PBC *Decision-Making Policy Manual*, and the Structured Framework on the organizational *decision field*;
- Discuss how facts related to mental health problems influence the *frame* in case-management files

8.1.1. THE SURROUND

Case-management Risk Rationalities

In Chapter Seven: Discussion of Findings I demonstrated that parole decisions in the decision registry were influenced heavily by actuarial, *insurance risk rationalities*. In fact, less than a handful of decisions in the registry did not contain any form of statistical analysis. Moreover, during the hearing process, I routinely observed parole board members cite the offender's actuarial risk scores directly to the offender. This observation further illustrates the extent to which everyone is aware how an offender is labelled and defined by his risk score.

However, quantitative forms of *risk rationalities* are not sufficient in and of themselves to explain the governing practices that are influencing the larger *surround* within which Canadian penalty exists (Hannah-Moffat and Moore 2005). For governmentality scholars working in the area of

correctional research, *rehabilitation* remains a strong *risk rationality* governing Canadian "penality" (O'Malley 2004; Hannah-Moffat and Moore 2005). Similarly, this study also found evidence of *risk rationalities* that extend beyond that of statistical and/or actuarial forms. As clearly demonstrated in Chapter Seven Table 6, parole board members systematically drew on diagnostic labels such as mental disorders as per the DSM-5 or the PCL-R, within the decision registry and during the hearing process. Insurance and actuarial risk logic alone cannot account for why therapeutic and clinical information (i.e. diagnostic information) is referenced in combination with actuarial scores in the risk assessment process especially when we consider that modern punishment is predominately "concerned with techniques to identity, classify and manage groupings sorted by dangerousness" (Feeley and Simon 1992 452). This new era of penology is characterized as shifting away from rehabilitative and clinical technologies, giving way to efficiency in the deployment of new techniques that target offenders as aggregate risk groups. On the contrary, this research has found that that all three data sources (decision registry, interviews, and the hearings) examined actuarial in addition to diagnostic and clinical information during the decision-making process.

As discussed in Chapter Four, the process of drawing on clinical information related to problematic populations to assess risk is linked with a qualitative *risk rationality* referred to as *case-management risk*. Understanding the techniques used within *case-management risk* logic allows us to see how patterns of governance construct mental health as a risk within the offender population (Rose 2002). Acknowledgement and documentation of mental health problems in the offender's file was shown in my analysis to be evidence of how parole board members construct the offender through diagnostic labels. However, since the diagnostic information is contextualized within a scientific framework, its presentation alongside actuarial scores within the risk assessment can lend to a powerful depiction of the flawed, disordered, and deviant offender.

This process of documenting diagnostic information is the manner by which offenders are targeted for the purpose of *selective incapacitation*, especially for those prone to violence such as those in the detention sample. Recall Chapter Seven's discussion of the manifest detention data where I found that detention cases had more references to mental health problems than DP/FP cases. In that chapter I suggested that parole board members may reference mental health problems more often because they must review a psychological assessment as part of the detention decision-making process. In other words, since parole board members are provided psychological information at a higher rate, in turn, they may reference that type of data more often. I would argue that there is another aspect to consider here.

Parole board members must follow a specific format when assessing offenders who meet the requirements for a detention referral. The intensive assessment process draws on case management risk forms such as diagnostic labels and clinical information (i.e. counselling and therapy notes) in addition to actuarial scores. The assessment process is intensified for this population by drawing on both individualized clinical and case management data as well as actuarial data to describe the level of risk associated with the offender. Understood this way, diagnostic information is just as important to this process of *selective incapacitation* as actuarial scores; especially with regard to those prone to violence. The current research provides an additional dimension to that process, especially as I also flag how important other processes of control, i.e. medication compliance, are to the decision-making process once a mental health problem is identified.

Drawing on clinical and therapeutic technologies of the self to understand and construct 'at risk' offenders feeds into the bifurcation process, that is, identification of those who are subject to "inclusion" versus "exclusion" strategies (Cohen 1985; Rose 1999). *Case management risk rationalities* are very influential to the parole decision-making process, especially the detention cases, those who have demonstrated through their continued pattern of extreme violence to be the *abjects* or "cast-

offs" of the offender population, the morally flawed offender who simply must be managed through incapacitation (Rose 2000). Contrary to Castel (1991), this research found that there has not been a "dissolution of the diagnosis of the pathological individual as the criterion of expert intervention". Instead for this population, the diagnostic labels and clinical information adds an important aspect towards constructing the offender as pathological, deviant, and/or 'at risk' offender[78].

I also observed how the practices associated with *case management risk rationalities* influence the decision-making process during the hearings. At the commencement of each of the 17 hearings the parole officer assigned to the offender reviews the "case". The parole officer verbally reviews relevant actuarial data, criminogenic factors, institutional progress, concerns, and diagnostic information. The offender is understood through the parole officer's review of their "case" and the hearing is organized around this file information. The parole board members then draw upon the case information to assess and construct the risk associated with the offender.

In Chapter Seven: Discussion of Findings, I described how parole board members drew upon clinical and diagnostic discourse to the service of particular legal rationalities such as incapacitation. Understood this way, expert assessments of the offender in the dossier become potential risks or red flags in the decision-making process. In one particular example, the offender could not recall the actual moments leading up to and including the killing of his partner. The file contained a clinical assessment of this event, and referred to this amnesia-like state as: *psychogenic fury,* a neologism not found in the diagnostic literature. The parole board member noted this reference as to a psychological condition, and then linked this incident with another example in the offender's social history where he went missing for a few days after receiving very stressful information about his daughter. In that incident, there was also an expert determination that the offender had experienced

[78] Weir (1996) raises same conclusions in her work on clinical risk rationalities

another episode of *psychogenic fury*. During the conversation between the offender and the parole board member, it became apparent that the influence of mental health hazard, the condition of *psychogenic fury,* would not be overlooked by the parole board member as it remained a potential hazard or risk in the future. Moreover, due to the psychologist's provision of an expert label for the phenomenon, neither the offender nor the psychological assessment could provide a plausible strategy that could mitigate the risk associated with a potential future episode. In effect, the *psychogenic fury* condition was assessed as an aggravating therapeutic risk that flagged the offender's inability to self-regulate on release[79].

To conclude, the high rate of reference to mental health diagnostic information among detention cases, high references to actuarial scores, and the denial of all detention cases in the current study, combine with my analysis of parole hearing comments to show a reluctance to release offenders with unmanageable mental health problems, which collectively offers strong support for *case management risk rationalities*. It is not surprising then that mental health problems are identified more often in detention cases, as the information serves an important purpose in the legal rationale.

Responsibilization Strategies

The ability of the offender to manage their mental health problems is an effective way to illustrate how he is able to self-regulate, and show responsibility in one's own self-management. I gave numerous examples in Chapter Seven: Discussion of Findings in which being medication/treatment compliant was presented in a positive light by the parole board members. Of

[79] As an aside, this process of documenting mental health problems in the file also supports the transparent" decision-making process regarding the detainment of those deemed too high risk to be released into the community (Castel 1991; Dean 1999; Rose 2002). Recall that the PBC states that the purpose of the decision registry "is to contribute to public understanding of conditional release decision-making and to promote openness and accountability. (http://pbc-clcc.gc.ca/infocntr/factsh/registr-eng.shtml 2015).

the nine DP/FP cases that made references to a mental health problem, three cases were granted parole. In all three cases, the parole board member described how the offender had actively sought out treatment and psychological services. For example, recall the following decision:

> You committed to participate in sex offender treatment programming in the community and enroll in a church-based pornography addictions program. Psychological file information dated XXX also reported that you had requested counselling services to assist in managing your chronic depression. However, prior to counselling, you were released into the community when your direct revocation was cancelled. Your Assessment for Decision dated XXX notes that you are presently on anti-depressant medication with no indication of any mental health issues impacting your risk while in the community (DP/FP 20)

On the other end of the continuum, there are mental health problems for which medication and/or counselling are not viable treatment options to convince authorities that the offender is capable of self-regulation. For example, this study revealed that in the case of the "psychopath", and/or those diagnosed as having significant personality disorders, the mental health problems are deemed too problematic or too risky in the parole decision-making process.

For Rose (2002), documented low risk mental health problems (e.g. depression) are managed by way of medication or psychological intervention. Alternatively, the highest risk mental health problems (e.g. sexual deviance) rely upon techniques for detainment, control, and security under the rhetoric of protecting the potential of harm to communities[80]. Rose (2002) articulates, "[f]or those thought to pose risks to others, the specter of preventative detention re-emerges. We have seen the birth of a new class of 'monsters'-sexual predators, pedophiles, the incorrigibly antisocial-for who a whole variety of paralegal forms of confinement are being devised" (Rose 2002, 219). These strategies are not necessarily novel, recalls Cohen (1985) in reference to the bifurcation of inclusion versus exclusion strategies in the management of different types of offenders. However, it Rose's work that we can draw on how these strategies are used in the governance of different types of

[80] See Cohen (1985) for further examination of bifurcation of inclusion and exclusionary strategies.

mental health problems. This framework provides a useful lens to understand the second section of Chapter Seven: Discussion of Findings. For example, gambling, substance abuse, and/or sexual deviance (although not necessarily understood by parole board members as formal mental health problems) are all often still the target of treatment efforts. Alternatively, psychopathy is understood by parole board members as a mental health issue but since it is considered untreatable, risk is often referenced as elevated and understood to be unmanageable. Being identified as a psychopath negatively influences parole decision-making.

Risk discourses about psychopathy shape understanding of what it means to be a "psychopath" (Cohen 1985; Federman, Holmes, and Jacob 2009). The current study strongly suggests that parole board members understand psychopathy based on discourses that perpetuate notions of this problem as being untreatable and/or unmanageable. Popular media also plays a significant role in this construction, namely the depiction of the psychopath as a morally flawed individual who lacks empathy, is self-serving, and encompasses a complete disregard for the rights of others with whom he/she may interact. Over time, these *risk discourses* about being a "psychopath" have become fused with other constructs, such as dangerousness and/or the mentally ill (Federman, Holmes, and Jacob 2009). Take for example, one recent empirical study that found that forensic mental health professionals, as well as the general public, associate mental illness and criminal behaviour with the construct of the psychopath:

> Psychopathy, like serial murder, is equated with evil in the public mind and conveyed through well designed atrocity tales […]. Media portrayals of extreme criminal psychopaths may have generated confused public ideas about the relationship between *psychopathy*, psychosis and other forms of psychopathology, and criminal behaviour. Cultural (subjective) and scientific (objective) definitions of *psychopathy* are likely to influence the social context within which crime and deviance are understood. (Helfgott 2013, 522)

Even with the author's effort to highlight how *risk discourses* have impacted public understanding of psychopathy, she reinforces the notion that psychopathy is not only a

social/cultural construction but it is also part of the social scientific construct. This linkage with empiricism reifies the scientific "truth" related to the construct (Federman, Holmes, and Jacob 2009). As a whole, what it means to be a "psychopath" influences the governing of those who are deemed unmanageable (Rose 2000, 334). Moreover, offenders labelled with psychopathy find themselves in a difficult predicament accessing conditional release. Even if theoretically psychopathy is not a mental disorder it is processed by parole board members as being an unmanageable mental health problem. This begs the question, how does an offender labelled with psychopathy negotiate or challenge this notion of being a psychopath if the *risk discourse* constructs them as not qualified to do so?

One final commentary on this section, I note that parole board members drew on the label of psychopathy in the formal decision registry only once, and that was within the context of articulating diagnostic information. Most of the references to psychopathy occurred in response to direct questioning of this construct during my interviews with former parole board members. More often the formal decision registry referenced only the actuarial tool that measures psychopathy (PCL-R). This distinction could suggest a difference between how the parole board members understand the PCL-R and psychopathy as separate constructs; however, I am not convinced. Parole board members are directed to anchor their decisions in actuarial risk scores. I would argue that the linkage between the PCL-R and the construct of psychopathy is so strong that when the reference to the PCL-R is made, it is done so in order to make a strong, 'empirical' claim related to the moral badness of the psychopathic offender. This underlying assumption of the psychopath as morally bad was also seen in the hearings. Even when the construct was brought up in the hearing, it was said in a negative tone, accusingly.

As noted in the discussion of psychopathy in Chapter Seven, I heard the parole board members reference psychopathy in two of the seventeen hearings, albeit as a direct label,

"psychopath". When it was referenced, it was in a negative context (see the chapter on psychopathy for a review of this). Conversely, the board member did not bring up the PCL-R in the hearing; favouring the label of "psychopath": This speaks directly to the extent to which PCL-R and psychopathy have become merged/confused into one entity whereby technology is identical to the concept:

> "You are extremely dangerous, your behavior is irregular, you are personality disordered, limited cognitive ability, severe character deficiency, psychopath, schizoid…" (Hearing 17)

The Expert

Neo-liberal forms of rule rely on the authority of various types of experts to inform larger governance strategies. The expert is also essential in the creation of *risk discourses* by playing a powerful role in labelling certain populations. Rose (1999) explains the importance of the expert in neo-liberalism:

> They identify those individuals unable to self-govern, and either attempt to re-attach them-training, welfare-to-work-or to manage their exclusion-incarceration, residualization of welfare. In short, 'free individuals', 'partners' and stakeholders are enwrapped in webs of knowledge and circuits of communication through which their actions can be shaped and steered and by means of which they can steer themselves (Rose 1999, 147).

As observed in the previous chapter, expert judgement is critical in the determination of an offender's mental health problems. This study also found that the offender had limited legitimacy in the claims of his own mental health problems. This can be explained in part by the privileged role experts play in substantiating mental health problems through application of psy knowledges compared to the assessment and/or opinions of lay people[81].

[81] Grinyer (1995) for example, found that expert knowledge is supported by "scientific knowledge" and is considered privileged in relation to lay actor. The dynamic I observed here was not much different. As discussed in chapter 7, the authority to determine mental health problems appears to rest with the expert. In fact, parole board members are less likely to recognize or substantiate mental health problems in their decisions without such diagnostic assessment.

The work of Castel (1991) is of importance in understanding the role of the expert in my findings. According to Castel, the role of mental health professionals has changed. The shifting role of the expert, once used to identify and normalize the "pathological" has now been transformed to establish *flows of population*, based on abstract factors that are associated with the factors of "risk". As Castel has argued, "the new strategies dissolve the notion of a *subject* or a concrete individual, and put in its place a combinatory of *factors*, the factors of risk" (1991, 281). He explains that mental health professionals historically provided an entire continuum of psychoanalytic care to those under their watch. This process is referred to as the *continuous regime of assistance* (Castel 1991, 290). He argues that the role of the mental health professional has been transformed and the involvement of these experts within the system now is to act primarily, as an *activity of expertise:*

> In a growing number of situations, medicopsychological assessment functions as an activity of expertise which serves to label an individual, to constitute for him or her a profile which will place him or her on a career. […] A diagnosis of handicap makes it possible to allocate subjects to various special trajectories, but these are not necessarily medical ones […]. Nevertheless, the intervention of the practitioner remains an essential part of the functioning of the process, since it is the practitioner's expert assessment which seals the destiny of the handicapped individual. But this expertise no longer serves the same end: while remaining indispensable as an evaluation, it can become superfluous to the process of supervision. In other words, there are a growing number of subjects who continue to have to be seen by specialists of medico-psychological knowledge whose intervention remains necessary for assessment of their abilities (or disabilities). But individuals who are seen in this way no longer have to be treated by these same specialists. We have gone beyond the problematic of treatment (or, in critical nomenclature, that of repression and control). We are situated in a perspective of autonomized management of populations conducted on the basis of differential profiles of those populations established by means of medico-psychological diagnoses which function as pure expertises (291).

This study reviewed cases wherein the offender did not even need to be present for an assessment of the offender to be rendered by an expert[82]. In these cases, in addition to the offender

[82] The Psychological Association of Manitoba published a letter regarding the defining principles proposed by CSC regarding non-consensual risk assessments. That letter provides recommendations as to how to proceed with regard to "psychological assessments" and "assessments" that are based on file reviews. While not discouraging these assessments, the group does underscore that these assessments should not contain any

being assessed as part of an "at risk" population, the parole board member also taps into a discourse around non-compliance with the case-management process. Not only is the offender understood in the context of his documented mental health problems, but by not participating in the assessment the offender's resistance is interpreted as not taking responsibility or accountability in his own rehabilitation.

This section has drawn on *case-management risk rationalities* within the surround to describe how mental health problems among "at risk" populations are understood by parole authorities. I drew on the decision registry, hearings, and interviews to establish how *responsibilization* strategies are an integral component within case management risk rationalities to construct the offender as responsible or non-compliant. Finally, I discussed how the expert is used in case-management risk logic to label and diagnose problematic behaviour in the context of the larger system of preventative surveillance. The following section will provide a theoretical description of my findings in relation to Hawkins' decision-field.

8.1.2. The Decision Field

Decision makers are trained through various methods to understand constructs in a way that is meaningful to achieve the organization's mandate. (Hawkins 2002). The organization establishes what information becomes relevant for decision-making and what ends are to be met through the decision-making process. As per Hawkins (2003):

> "Criminal justice decisions are made in the broader setting of a surround and within a context, or field, defined by legal and organisational mandates. Such decisions are made in a rich and complex environment, which acts as the setting for the play of shifting currents of broad political and economic values and forces. Decision frames, the interpretive and

---

opinion regarding the current mental status of the offender and/or newly administered actuarial scales (Manitoba Psychologist Fall 2007).

> classificatory devices operation in particular instances, are shaped by both surround and field. To understand the nature of criminal justice decision-making better, a connection needs to be forged between forces in the decision-making environment, and the interpretive processes that individuals engage in when deciding a particular case" (189)

The *decision field* is comprised of ideas related to how the organization operationalizes its expectations at the formal and the informal level (Hawkins 2002). In the following section, I will review the formal properties of the *decision field,* such as the legislation and policies involved in the conditional release process, (i.e. CCRA, The Decision-Making Policy Manual, and the Structured Framework) and discuss how these formal properties influence parole board members' understanding of mental health problems. I will then discuss the informal properties of the field.

Formal Properties of the Decision-Field

The formal properties of the parole decision field are the written forms of the laws, the guidelines, and the rules that govern decision-making. According to Hawkins (2002), the law marks the boundaries of the decision-field and inform the policies that the organization must abide (143). Chapter 2 discussed in detail the influence of the promulgation of the *Corrections and Conditional Release Act (CCRA*) in 1992 on the correctional field. Parole board members are formally bound by the *CCRA* as the legal framework that communicates the general mandate of the PBC. Various *Bills* have affected parole decision-making and amended the CCRA since its inception. For example, *Bill C-67* introduced changes to the legislation of conditional release that eliminated the automatic release of certain high risk offenders beyond statutory release. There was also *Bill C-59*, an Act to amend the Corrections and Conditional Release Act (accelerated parole review) in order to abolish early conditional release for offenders serving their first non-violent offence. These legislative changes represent a part of the surround that were linked to Canadian political discourses around the "get tough on crime" agenda (Fournier-Ruggles 2011; Jackson and Stewart 2009), which subsequently had a consequential effect on the formal decision field. This meant that the changes in

the conception of risk within the political field influenced an entire classification of offenders. These that had been previously considered a low risk to public safety, were no longer eligible for early release under the *CCRA*. I link the reason for these changes to the *CCRA* exclusively to the political construction of risk[83].

The *CCRA* has been very prescriptive as to how the PBC articulates and defines its purpose with regard to conditional release. The PBC and the CSC, as organizations involved in the conditional release decision-making process, are responsible for translating this construct of risk into policies in order to fulfill the spirit of the legislation (Tkachuk 2000). As per a CSC presentation on the systemic approach to risk assessment and management, the organization must consider the following facets in order to achieve its mandate:

- Sustaining an organizational focus on the importance of risk so that our sensitivity to risk – and to the protection of society – is an ingrained part of our culture
- Developing information gathering and reporting processes which contribute to quality decision-making
- Acquiring and employing empirical knowledge about criminal behaviour so that our determinations are understandable, and defensible
- Implementing necessary organizational controls

(Tkachuk 2000)

Policies flow from the larger legislative framework and are instrumental to the operationalization of the law. According to Hawkins (2012), while the law determines the contours and reach of the PBC and CSC, it is the responsibility of the organization to translate this into a unified vision. With respect to mental health however, the CCRA s. 85-89 is prescriptive as it speaks to the obligation of

[83] It has been argued however, that the true impact of changes to the legislation linked to these *Bills* or for APR for that matter, remains widely misunderstood as the numbers of impacted offenders are masked by way of government statistics (Campbell 2014).

CSC to recognize and treat mental health problems. Furthermore, it is prescriptive through recommending that the offender's mental health needs are taken into consideration in all decisions related to the offender. The specific tenets of CCRA s. 85-87 are as follows:

"health care"

> "health care" means medical care, dental care and mental health care, provided by registered health care professionals;

"mental health care"

> "mental health care" means the care of a disorder of thought, mood, perception, orientation or memory that significantly impairs judgment, behaviour, the capacity to recognize reality or the ability to meet the ordinary demands of life;

"treatment"

> "treatment" means health care treatment.

Obligations of Service

> **86.** (1) The Service shall provide every inmate with
>
> - (*a*) essential health care; and
> - (*b*) reasonable access to non-essential mental health care that will contribute to the inmate's rehabilitation and successful reintegration into the community.

Standards

(2) The provision of health care under subsection (1) shall conform to professionally accepted standards.

Service to consider health factors

> **87.** The Service shall take into consideration an offender's state of health and health care needs
>
> (*a*) in all decisions affecting the offender, including decisions relating to placement, transfer, administrative segregation and disciplinary matters; and
>
> (*b*) in the preparation of the offender for release and the supervision of the offender.

In February 1998, the Canadian government endeavoured a 5-year review of the CCRA Health Services. One of the results was a working paper (consultation report) written in collaboration with numerous criminal justice departments and agencies. I note various issues related to the CCRA's

influence on health care services for the offender population. In particular, the paper raised an issue relevant to the purposes of the present:

> The third issue identified in the project plan addressed the extent to which the offender's state of health and health care needs are taken into consideration in decisions affecting the offender and in the preparation for release and supervision of the offender (Section 87 of the CCRA). Once again, the CSC Health Services policy documents were reviewed. In addition, the Case Management Manual (CMM) was also reviewed since it is the primary document providing procedures and guidance to the case management officers. It provides detailed guidelines on the information to be considered and the format for reports to be used for recording this information for the decision-making process.
> The Health Services Manual outlines the requirement of Section 87 that any person preparing documentation for a decision must include a discussion of the offender's state of health and health care needs. The CCRA provides examples, but not an exhaustive list of the decisions for which the offender's state of health and health needs shall be considered. A complete listing of the decisions to which this section of the CCRA applies is not provided in the Health Services Manual, the Standards for Health Services or the CMM. There is no guideline provided in these documents as to what type of information describes the state of health or health care needs of an offender. Another issue which warrants examination is whether the type of decision has a bearing on the type or amount of health information that is relevant. In addition, the issue of confidentiality of medical information and the professional requirements relating to confidentiality of patient medical information (to which health professionals are, in many cases, legally bound) is not addressed in relationship to the CCRA Section 87 requirement in the policy or procedures documents. A clear definition of both state of health and health care needs would allow CSC's health professionals to provide a consistent set of health information for use in the case management process (1998, 20-21).

The working group clearly state their concerns with how decision-makers describe mental health needs of the offender and the extent to which decision-makers draw on confidential health care information in the case management process. I would argue that the current research has underscored the same issue; however, I have moved beyond a recognition of identifying the need to clearly define the health and healthcare needs of the offender as discussed in the Consultation Paper, to note the implications of decision-makers drawing on mental health concerns located in the case management documents. In my analysis of the surround within which parole board members make decisions, I explained that case management documents draw on diagnostic information in the risk assessment process. The offender's dossier is an accumulation of risk logics that acquire and employ

scientific knowledge about the offender in order to understand the total risk sum, so to speak, that the offender presents to public safety. Therefore, not only is health related information used in the case-management process, it is used to create a risk profile of the offender. The health care information therefore, is not being used commensurate with the intention of the law, i.e. to inform the offender's needs. Instead, I argue that the risk assessment process has appropriated the information for its own needs. Especially with regard to how the offender manages his mental health needs. In fact, in one particular striking moment in the parole hearing, a decision-maker seem to deflect any responsibility of ensuring that the decision-making process examines the mental health needs of the offender. Recall the example in the hearing where the offender's assistant challenges the parole board member to consider their responsibility in the process:

Assistant	He is 37 and he has a meal house of offending, needs to be helped with esteem, job, feeling attached, doesn't have friends, he needs therapy to address his paraphilia – perhaps he can treat it
PBM	"that's not what the research says"
Assistant	It is part of supervision: lawyer and parole board could brain storm
PBM	"not our mandate to brainstorm"
Assistant	"what about trying to keep the public safe? Treating the sex offending, COSA, NA, I am sure the therapy can help him, offending as much as he has, increase the insight
PBM	Addresses the offender: this is your "last kick at the can", an opportunity to tell the board the reasons you have cognitive distortions (Parole Hearing 1).

It is interesting to note in this exchange that the offender's assistant is raising the argument that addressing the mental health needs of his client through provision of therapy to address paraphilia could "keep the public safe", which is aligned with CSC mandate to rehabilitate the offender to

reduce risk to the public. The parole board member, however, appears to draw upon "research" to classify the paraphilia as untreatable, with the inference being there is no "need" to be addressed.

The following section will expand further on the decision-field and explain the influence of the Structured Framework and the PBC *Decision-Making Policy Manual* in the decision-making process. I argue that these two administrative documents are the mechanisms that translate the principles of the *CCRA* into organizationally desirable ways to achieve their larger mandate to assess risk (Hawkins 2002, 33).

The Decision-Making Policy Manual

The *CCRA* requires that the PBC adopt policies to inform and guide parole decisions. These policies provide the framework and guide decision-making by Board Members. The *PBC Decision-Making Policy Manual* (and training manuals) are intended to guide parole board members must follow so they are consistent with the larger objectives of the PBC. These manuals rely heavily on actuarial tools that support a larger realist risk-assessment process. Specifically, the policy manual sets the requirements for the parole decision process, i.e. the parole hearing, required timelines, responsibilities of the actors involved in the process, identification of the specific assessments and/or documents required that inform the decision-making process. The policy manual also structures the decision-making by identifying the relevant factors for assessment, therefore streamlining large amounts of information, schematically and efficiently.

With regard to mental health problems, the PBC's *Decision-Making Policy Manual* instructs parole board to specifically assess for; the presence of a mental disorder, sexual deviance, and substance abuse (all considered mental health problems as per the DSM-5). This instruction is based on the understanding that these factors affect self-control. Ergo, it is no surprise that parole board

members draw on this information in the decision-making process, as this is a specific requirement outlined in the policy manual, provided below:

Assessing Factors Affecting Self-Control

9. Information considered when assessing factors affecting self-control includes:
   a. elements that relate to the offender's ability to regulate their own behaviour and the extent to which the offender is impulsive or easily angered;
   b. the presence of a mental disorder, sexual deviance or level of intelligence which interferes with the offender's ability to make law-abiding choices;
   c. the presence of substance abuse which prevents the offender from adequately controlling their behaviour; and
   d. information indicating that the offender is vulnerable to the influences of criminally oriented associates, possesses attitudes and values that support criminal behaviour or has anti-social personality or behaviour.

(PBC Decision-Making Policy Manual *2.9*)

As I found in Chapter Seven: Discussion of Findings, locating substance abuse in a different category than a mental disorder greatly influences how parole board members understand substance abuse, namely a risk factor and not a mental health problem. However, the policy is not so rigid as to precisely influence decision-making, instead the policy provides broad categories for the parole board member to understand vast amounts of information:

> In the abstract, policy may appear to be the embodiment of an instrumental expression of law. In practice, however, various opportunities are opened up for the making of expressive decisions in the actual processes of decision-making, since policy is not impervious to the wide variety of extraneous forces which come to be superimposed upon inspectors' decision-making. The problem for bureaucratic policy is not simply the extent to which it can effectively be communicated within the organization; so much as whether it is able to overcome the practical imperatives that determine what inspectors do (176)

This quote helps to explain why I found great consistency across parole decisions related to substance abuse being or not being understood as a mental health problem; however, I also found

variance related to how gambling was understood in parole decisions. Parole board members are directed to assess substance abuse separately from that of a mental disorder. Once there is evidence of gambling being a mental disorder or being labelled a mental health problem by an expert, the parole board member is then directed as per 2.9 (b) of the policy manual to assess how the disorder interferes with the offender's ability to make law abiding choices.

Techniques of accounting such as audits, and other performance monitoring functions are built into the PBC organization in order to ensure consistency, efficiency and uniformity in relation to adherence to the policy manual[84]. The PBC regularly audits and reviews decisions from a regional and national level in order to verify consistency against the policy manual. In addition, a parallel, reactive investigative process can be initiated by the PBC that reviews decision-making following a significant incident with an offender while on conditional release[85]. These audit techniques exist inside a larger, accountability and transparency process for PBC decision-making within a larger neo-liberal *surround*.

Parole decision makers are trained to write in a structured manner to ensure consistency among decisions. This structured format, linked with the structured framework, is adhered to so closely that in reviewing the formal parole decision registry I was able to create a template that parole board members employ to systematically review the case-management file for pertinent risk related information[86]. Templates assist in this goal as they act like a checklist that guides the decision maker through a series of areas in order to come to an informed, but structured, outcome as per the larger organizational goals.

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[84] See Rose (2000) for the discussion on the role of audits in risk logics.

[85] Section 152(4) of the CCRA: the Chairperson of the PBC may appoint a person or persons to investigate and report on any matter relating to the operations of PBC.

[86] Although I did an ATIP request for training manuals and templates used by parole board members in their decision-making process, I was denied access to these documents.

Recall in Chapter Seven: Discussion of Findings that the formal template that guides parole board members through various factors for analysis in detention cases directs parole board members to identify mental disorders in one category and sexual impulses in another. In this way, the template influences how the parole board understands and documents concepts such as sexual deviance and mental disorder. Training and training manuals also provide the same effect in ensuring that parole authorities make decisions consistent with the values of the organization. Importantly, I identified outliers or exceptions to my findings. For example, I note in the previous chapter one parole decision was written from a mental health lens, whereas the other three were not. I attribute this difference to the individual frame of the parole decision maker. I expected to find these outliers in a small qualitative sample.

The Structured Framework

PBC implemented Serin's (2004) structured decision-making framework in an effort to guide decision-making through a systematic and consistent process. The framework allows for various ways that parole board members can consider mental health problems. For example, is the offender able to self-regulate his mental health problems (i.e. behavior)? Is the offender compliant with his medication program? I discussed significant evidence of the parole board member assessing mental health problems in relation to the structured framework in the previous chapter. Case in point, the influence of the structured framework on decision-making related to the offender's release plan can be obvious, as follows:

> Your proposed release plan is assessed as inadequate to manage the risk you now pose to the community. You say you want to take a child and youth worker course or join the army. These are plans you wish to pursue after you go to school and work, possibly in construction. You feel you require ongoing psychological counseling. Although you have gained some insight into your crime cycle, relapse plan and the triggers which would cause you to return to a lifestyle of crime, it is questionable as to how you have internalized it. (DP/FP 3)
>
> Your full parole release plan is to reside with your parents and continue your employment and psychological counselling. The Correctional Service of Canada (CSC) describes you as diligent in meeting your obligations and recommends that full parole be granted, as they believe your risk is manageable in the community. You have made positive progress during your release and are reported as motivated to adhere to your correctional plan. (DP/FP 7)
>
> Your release plan is to reside with your girlfriend in XXX. CSC considers this community too isolated for proper supervision, and would only evaluate you for residency if you agreed to treatment. (Detention 11)
>
> The Board also notes that while you did make progress through your participation in psychological counselling, you decided to end before tolerance to frustration, capacity to set realistic goals, and perseverance could be addressed, this despite the urging of your CMT to continue. The Board would also note that the pain you feel for having participated in the death of your lover is still visible and may need to be explored given that the nature of relationship with the victim has only recently been discussed. The Board is also of the opinion that your release plan is premature in the sense that your focus appears to be on maintaining your abstinence and improving your education and ensuring your days are filled to ensure that you are not tempted to return to previous patterns of behaviour. (DP/FP 24)

While the policy manual directs the parole board member to draw on specific information, the structured framework guides the parole board member on how to understand the information. Overall however, the *CCRA*, the PBC Policy Manual, and the Structured Framework are all examples of the formal properties that are influencing decision-making as it is relates to mental health. Without an understanding of how these formal properties shape the depiction of mental health, I would not have been able to fully appreciate how parole board members understand mental health. An analysis of the decision field also provides an explanation of how concepts such as sexual

deviance and substance abuse were consistent across parole decisions in the registry and in the hearings. These formal properties are powerful influences on the decision maker.

Informal Properties

The Hearing

From a dramaturgical point of view, the hearing can be understood as a scripted stage performance in which various actors participate in a scene or a *frame*. The offender, therefore, cannot be understood autonomously from the social context. In fact, it is because of the *frame* that he is even understood as "the offender'. It is within the interaction, as it is acted out by all participants (the parole board member, the offender, and the audience) with the assistance and rituals of the theatre that the offender is understood (Goffman 1959, 252–253).

In Chapter Seven, I discussed the case of an offender who was understood as suffering from gambling problems. In that example, the offender and the parole board member interact to construct the offender as a rehabilitated offender who can manage his mental health through the aid of his social supports, namely the psychologist referenced numerous times during the hearing. In other words, social reality was constructed through the interaction of the offender and the parole board member.

I note that there were two hearing cases where the parole board member discussed the offender as a "psychopath". In both circumstances, the offenders did not object to this construction of him as a person. Instead, the offenders simply looked down and lightly shook their heads resulting in an implicit agreement in the understanding that were indeed, "psychopaths".

Alternatively, I identified important and obvious *breaks* from character by the actors as well. That is, moments when the actor steps out of character for reasons that are not planned, nor fit with the frame. As a participant observer, these breaks were obvious and they provided a clearer

understanding of how the intended hearing process was supposed to proceed. For example, during one hearing an offender serving an indeterminate sentence cried out that he did not want "to die in prison". The same offender often screamed out in agony due to back pain, forcing the parole board members to make a concerted effort to refocus the offender to the specific and scripted hearing process (Hearing 9). Another example relevant to the issue of mental health was when the offender indicated that he had not had his psychological assessment shared with him prior to the hearing. This forced the parole board members to halt the hearing in order to ensure that the offender had an opportunity to review the psychological risk assessment written about him by one of the many psychologists that had assessed him. The 10 minutes that the offender was afforded to review the report met the policy requirement that he was "shared" the information that was being used to inform a decision on his case. Arguably, one could link this "sharing of information" or "the break" as part of the formal rituals (all information must be shared with the information in order for the PBC to render a decision on the offender) and props (expert assessments) used within the theatrical performance that subsequently formalize the process as legitimate.

Based on my observation of the hearings, I found that parole board members did not necessarily know how to proceed when mental health information was raised in the hearing outside of the structure prescribed by the PBC (Manning 1986, 1293). For example, at the end of one hearing the offender's assistant brought up that the offender suffered from mental health problems that rendered him incapable from understanding the larger context of the parole hearing suggesting that this was why the offender was not able to focus and respond precisely to the questions the parole board members were asking. The assistant went on to make reference to a neuro-psychological assessment on file that provided more information on the offender's cognitive vulnerabilities. At that time, the hearing was near completion and I could understand that it would have been difficult to return to numerous points in the hearing in order to ascertain the impact of

the offender's cognitive functioning on his responses to the parole board members. Not only had the hearing taken a few hours, but it would have meant that the analysis up to that point was somehow skewed. In response to the assistant's concerns, the parole board member simply moved forward to the next and final stage of the hearing, where the offender could state his final comments. In fact, before informing the offender that he could say his final words in the hearing, the parole board members asked the offender to provide simple responses to the parole board member's questions, noting that he felt that the offender "tended to ramble" throughout the hearing (Hearing 9). Interestingly, this was what the assistant had attempted to explain to the parole board members, that his rambling was in fact linked to his mental health.

Overall however, based on my experience in observing the 17 hearings, given the highly structured format, there were very few instances where the interaction veered from its intended and routine format. In fact, when the offender attempted to veer from the intended trajectory, the parole board member corrected the process immediately. This constructed reality serves to streamline information for decision-making.

This analysis of the *decision-field* provides a useful way to understand how the PBC as an organization is structured around a common mandate and how they go about achieving that mandate. The CCRA, the PBC *Decision-Making Policy Manual* and corresponding training manuals, as well as the structured framework strategically guide parole board members to process information through risk-based logic linked with larger *risk rationalities* percolating in the *surround*. Risk assessments and actuarial tools streamline extensive data into a unified risk-based language. This risk language is therefore a shared language by professionals within the organization as a whole. Within this context, mental health problems are flagged as risk factors; however, they are considered in a very structured manner as defined through law and policy. Finally, the structure of the decision field allows us to see that simple referencing to mental health is not necessarily evidence that the parole

board members understand the mental health problem. Instead, the requirement to review mental disorders and diagnostic information is closely linked to the organizational structure, and should not be confused with a true understanding of the concepts.

8.1.3. Frame

In my theoretical contribution chapter, I reviewed numerous studies that have examined the various influences on parole decision-making. I found few qualitative studies that reviewed these influences. In fact, the existing research suggests significant discrepancies on decision-making. This study has thus far avoided an outcome based analysis. I have argued earlier that outcome based studies fall short of understanding the decisions in the context in which they were rendered. This research has gone to great lengths to illustrate how influential contextual information and organizational structures are on parole decisions. Thus far in this chapter I have demonstrated how parole board members understand mental health through the influence of the *surround* and the *decision field*. Here, I will build on the analysis by describing the influence of the *frame* on decision-making. I found that *framing* was such a strong influence on a parole board member's understanding of mental health that entire categories of mental disorders as per the DSM-5 were not operationalized as mental health problems but instead re-conceptualized into risk factors. I draw heavily from the second section of the previous chapter to support this finding. Beginning with the case of gambling and then moving to cover sexual paraphilia and substance abuse, I will detail how parole board members understand mental health linked to their organizational lens.

Gambling Behaviour as "Fact"

In the previous chapter, I observed the difference in how gambling behaviour was constructed in parole decisions. In two of the five cases that mentioned gambling behavior, gambling was referenced as an addiction whereas in the other three cases it was linked to financial stress/gain. I

can think of two reasons that could explain why the case management file would depict gambling problems in different ways.

First, there is no way of knowing as a researcher or observer in the process if there was actually a psychological assessment on file. Parole board members do not necessarily state if one was completed. Mental health assessments are expensive and time intensive for the correctional service. Consequently, not all offenders receive a psychological or mental health assessment. The offender only receives a psychological risk assessment if pursuant to CSC *Commissioners Directive (CD) 712*. Otherwise, the case management file may not contain an expert or psychological assessment of the offender's mental health status.

I observed in the hearings that in the cases where the offender was identified as having a gambling addiction, the offence did not meet the criteria for requiring a psychological assessment as per CD 712. However, in one of the cases, since the offender attended a gambling program through a community psychological program prior to his incarceration to federal custody, there was a psychological assessment on the offender's file. This psychological assessment framed his gambling behaviour as a mental health "problem" using diagnostic language. One can only speculate as to how his gambling behaviour might have been understood by the parole board members without this assessment. Also, other important details in the file influenced how his case came to be written. For example, the most obvious detail was that the offender used a gun in the commission of an assault against his victim. This received very little weight in the overall theatre of the hearing. Also, early case management documents could have assigned him to correctional programs at the commencement of his sentence in order to address risk factors linked to financial greed or the violence associated with the assault. Inevitably, the understanding of the "case" would have changed the trajectory of the decisions made on his file, the details within the hearing, and perhaps the final decision.

Another import aspect of this case was that one of the parole board members was a former police officer and it was made known in the hearing that the offender's brother who was present, as an observer, was also a police officer. As discussed in the decision-field, the hearing is a result of all the actors participating in theatre. Therefore, I cannot exclude the influence of the brother as an active participant in the construction of how this case unfolded however I do note that the presence of his brother had implications on the decision-making process. This is a great case to illustrate how important context is to the understanding the multitude of factors influencing the decision-making process.

The second reason that explains different depictions of gambling builds upon the first. Facts in complex files such as criminal justice cases are often framed through various perspectives in large dossiers, or what Goffman (1960) refers to as "paper reality". This means that the decision to grant parole is one of numerous decisions made on the file and the final decision is simply a continuation of the cumulative effect. Drawing on the case above where gambling is initially constructed as a mental health problem, one could argue that the same case could have unfolded differently depending on who the decision maker was and the *frame* applied by the decision maker.

I argue that the offender with a gambling addiction versus a greed as a moral problem are constructed as two very different cases and decision-making flows from how the offender has made progress in relation to "*the facts*" as they are *framed* in his case. To this point, the offender within the gambling data set who was designated to have a mental health problem and was able to illustrate that he could manage the problem through treatment was granted parole. His treatment was understood favourably in the decision-making process. Arguably, if one simply analyzed decisions by their outcome, (i.e. granted parole or not) this nuance in the data would be lost. Nonetheless, whether the parole board members understood gambling as a mental health problem or as greed, they were assessed based on abstinence.

Mental Health as a Construction of Risk

I discussed above that policy documents guide the parole board member through a series of "factors" for assessment. Based on my data sample, categories of mental health problems were linked with criminality based on how these factors were defined by the organization. Goffman refers to the propensity to locate around a central objective as a *cosmology* "a group's framework of frameworks-its belief system" (Goffman 1974, 27). The belief system of the group or organization informs and frames decision-making. In Hawkins' model, the various aspects of the *surround, decision-field*, and the *frame* each have a direct influence on one other. The decision-field defines the contours of decision-making. In other words, it has a direct effect on how correctional professionals interpret and understand that field. According to this logic, substance abuse and sexual deviance are defined by PBC and CSC as criminogenic risks.

These constructs defined through the PBC *Decision-Making Policy Manual* influence how parole board member understand and internalize data, concepts, and information in the offender's dossier. In this way, a psychologist or an employee working for a mental health organization may interpret constructs such as sexual deviance and substance abuse through a *frame* consistent with the group's belief system. The way the group understands the concepts is shared amongst group members, and in the case of mental health organizations understandably through a mental health lens.

It was made clear by the current study that parole board members understand constructs in accordance with the larger organizational constitution of risk logic as determined by the PBC based on realist risk research. This explains why all parole board members during the hearings informed me that they did not understand substance abuse as a mental health problem. Consistent with their training, substance abuse is understood as a risk factor. It is worth mentioning that it also explains why the one parole board member who informed me that he felt that substance abuse was not understood as a mental health problem in his decision-making process also volunteered that he

understood that his family member suffering from alcoholism had a mental health problem. I would argue that this dissonance is a reflection of his family's belief or "cosmological" understanding of the behaviour through a mental health lens whereas his professional group belief is that substance abuse is a risk factor.

The final section of Hawkins' framework analyzed the way in which parole board members understand certain behaviours as mental health problems within the decision-making process. By drawing on Hawkins' conception of "facts", which is closely linked to Goffman's notion of "paper reality", I am able to describe why parole board member understand some diagnostic information as per the DSM-5, as criminogenic risk factors, and vice versa, as a mental health problem. By understanding the influence of cosmology, I explained how law and policy influences the decision-making of individual actors.

8.2. CONCLUSION

In this chapter, I have examined the key themes in my research and presented these findings within Hawkins' (1986) conceptual decision-making framework. I have supplemented this analysis with concepts from the governmentality literature, namely case-management risk rationalities, responsibilization strategies, and the role of the expert. I have detailed the role of *formal* (the CCRA, PBC *Decision-Making Policy Manual*, and the Structure Framework) and *informal* properties (the hearing) within the decision field. I have further detailed how these organizational requirements heavily influence what information is important for parole board members to assess as defined by the organization.

Finally, I have discussed the influence of how "facts" frame case management dossiers and the impact on decision-making. Taken as a whole, this comprehensive analysis has moved beyond an

interactionist framework to bring a breadth of understanding to the larger socio-political, organizational and individual influences on decision-makers in parole decisions. The following is a visual representation of this chapter:

Table 8: Themes, Findings, and Theory

Surround Themes	Findings	Theory
• The Psychological Assessment • The role of the Expert • Self Regulation • Medication	• Diagnostic Information is used in the decision-making process • The expert substantiates the existence of an offender's mental health problem • The offender has little claim to problems with his mental health • The offender is understood as responsible for the regulation of their mental health • Management of an offender's mental health is understood as a positive factor in the decision-making process • Medication compliance is a critical factor in the decision-making process	Hawkins • Surround Governmentality • Risk Rationalities • Expert • Responsibilization Strategies
Decision-Field Themes		
• CCRA • PBC Decision-making Policy Manual • Structured Framework	• The CCRA and the policy manual influence how parole board members understand mental health • PBMs draw on diagnostic information to construct sexual deviance as a risk. • Substance Abuse is not understood as a mental health problem • Mental health is understood through a treatable vs. untreatable dichotomy • The construct, psychopathy, is used informally in the decision-making process and is understood as a mental health problem generally	Hawkins • Decision-Field Goffman • Presentation of Self
Frame Themes		
• Facts	• Gambling is understood as a mental health problem insofar as it is determined to be one by an expert as a fact • The PBC cosmology, the organization's belief system, influence parole board members to understand substance abuse and sexual deviance as risk factors • Parole board members do not necessarily understand diagnostic labels as intended as per the DSM-5 although they reference the concepts	Hawkins • Frame Goffman • Frame analysis • Paper reality • Cosmology

Chapter 9. Concluding Remarks

This dissertation allowed me to deconstruct issues related to risk. I drew on conceptualization of mental health and sources of information used to define these factors, all within federal corrections and their processes surrounding conditional release. The dissertation examines these issues through four central questions:

1. What information and sources do parole board members draw upon to ascertain the presence and/or extent of mental health problems? For example, do parole board members draw only upon formal diagnosis as a salient factor for assessment or do they also draw upon, and if so in what ways and to what extent, other contextual data such as compliance with treatment and/or medication issues?
2. How do parole board members operationalize mental health in parole board decisions? How is information about mental health problems referenced and used in the record of decision-making?
3. How are mental health problems framed by the Parole Board of Canada (PBC) in its policies and procedures?
4. How does an indication of mental health problems inform the discussion on release?

This research shows that parole board members draw upon diagnostic or clinical labels as a salient factor within the risk assessment process. As I have demonstrated, parole board members reference diagnostic information as part of a larger scientific-psychological construction of the offender. I had not expected to see the combination of diagnostic information with actuarial scores.

However, the findings support the argument that clinical interviews/ diagnostics are relevant risk assessment information. This is referred to as *case management risk rationalities* (Weir 1996; Dean 1999).

In the parole decision-making process, the presence and extent of mental health problems are determined by the expert, not the offender himself. This is a strong finding of this study, and is, in and of itself, a significant contribution to the literature of mental health in parole decision-making. Another strong finding of this research is that once a mental health problem is established by an expert, self-regulation and medication compliance become important factors of analysis in the parole decision-making process. Therefore, to some extent, the current study supports recent research conducted by Matejkowski (2010) who found that offenders with mental health problems may not be discriminated against in parole decisions as per earlier claims (Feder 1994; Porporino and Motiuk 1995). More specifically, this dissertation found that the better the offender manages their mental health problem(s), the more likely the parole board members responded favourably to those mental health problems in the parole decisions. I found the inverse as well, the presence of unmanaged, untreated mental health problems pose a negative influence on parole release decisions. This suggests a conundrum for offenders diagnosed with personality disorders and psychopathy, as well as organic disorders such as reported problems associated with FASD. This research found that parole board members understand these types of mental health problems as aggravating risk factors, since parole board members conceptualized these types of mental health problems as being unmanageable by way of medication or counselling.

Medication compliance has a significant influence on parole release decisions. This of course, creates the ultimate challenge for offenders with mental health problems who do not even recognize their mental health problems and resist treatment or a medication regiment. For anyone who has lived with a mental health problem or alongside someone suffering from mental health problems, a common feature of mental health difficulties is a lack of insight into their presence and how they

impact one's thoughts, feelings, and emotions. Mental health problems are such that people have trouble coping and managing them in the first place, that is their *problem*. These problems subsequently influence other spheres of their life, those areas that PBC and CSC identify as "criminogenic factors" (employment, attitudes, education, stable residence etc.). Matejkowski's (2010) study speaks to this influence and the extent that these problems negatively impact parole release decisions.

This study also responds to other limitations in the existing parole decision-making and mental health problems research. Matejkowski (2011) highlighted potential issues connected to how mental health problems were operationalized in his study of parole decision-making versus how parole board members operationalized mental health (4). This research demonstrated ways in which parole board members draw on diagnostic information in their decisions, specifically finding that parole board members do not necessarily understand mental health problems as per the DSM-5. I found that parole board members understand sexual deviance as a risk factor, although they draw on diagnostic labels to characterize the risk. Similarly, this research found that despite established links to substance abuse as a mental health problem parole board members do not understand substance abuse as a mental health problem, nor do they draw on diagnostic labels in their decision-making analysis of substance abuse problems. This research also established the differences in how parole board members understand and conceptualize gambling, involving the role of the expert into the process. Finally, in relation to how parole board members operationalize mental health, this research provided some very preliminary support that for the notion that the clinical concept of psychopathy while not identified as a mental disorder, might be understood as one by some legal actors or decision-makers.

Organizational and individual framing construct or constitute information in the offender's dossier as a mental health problem or a risk factor in order to facilitate the decision-making process

to meet the needs of the organization. Law and policy also heavily influence how mental health is operationalized. For example, the CCRA, the *Decision-Making Policy Manual* and corresponding training manuals, as well as the structured framework strategically guide parole board members to process information through risk-based logic linked with larger *risk rationalities* percolating in the *surround*. Within this context, certain mental health problems are re-conceptualized as risk factors. Law and policy induce parole board members to draw upon and reference mental health, and the requirement to review mental disorders and this diagnostic information is closely linked to the organizational structure to do so. As this research demonstrated, acknowledgement of a mental health problems within an offender's dossier should not be confused with evidence that parole board members have a grasp on the diagnostic understanding of the concept, as per mental health professionals.

9.1. AREAS FOR FUTURE RESEARCH

Although this research is able to contribute to a better understanding of the role of mental health in parole decisions, it also poses new questions and themes for future research:

9.1.1. Gender Differences

This research only reviewed male offenders. Although I did not include it in my sample, the PBC accidentally provided me with a written parole decision from the registry of one female offender. I note that there was extensive discussion of her mental health in the decision. Given my professional interests, this would be a very obvious avenue to pursue in future research. I recognize that professional experience in this area could enhance a better understanding whether women's mental health problems contribute to their risk profile. Based on this research, I predict that I would see a stronger mental health theme emerge in this population.

9.1.2. Regional Difference

There are significant differences in the makeup of the various regional offices across Canada. In fact, 11 out of the 17 cases that I observed had at least one former police officer rendering a decision. The influence of this cannot be overstated; especially if we consider the role that *framing* has on the parole decision-making process and the larger *get tough on crime* agenda[87] (Doob, Webster, Manson 2014) that influenced the criminal justice field during the time I conducted this research.

9.1.3. Acutely Mentally Disordered Population

This research focused on the general population of offenders. I did not screen the data for offenders having a "major" mental illness. Moreover, I note that Correctional Service of Canada has five regional treatment centres across Canada where offenders can reside during their sentence to receive treatment for their mental health problems. During informal conversations with parole board members, I was often asked why I was not studying that population. My response was consistent in that I was conducting exploratory research on how basic mental health information is understood in the decision-making process. I suspect that further examination into the decision-making process of offenders who are actively suffering from mental health problems would build on the findings from this research-especially with regard to my theme of self-regulation and medication compliance. Namely, I would be curious to ascertain if offenders who seek out treatment for their mental health problems, yet remain acutely ill, are understood differently by parole decision-makers? How influential are the release plans for this population if these plans involve release to a treatment centre versus a generic plan? Do board members spend more time during the decision-making

[87] Mary Campbell, retired Director General of Corrections and Criminal Justice Directorate discusses the extent of the get tough on crime agenda from a Canadian bureaucrat perspective (Quan 2013)

process discussing their mental health and if so, how do these conversations provide further insight into how mental health problems are understood in the release process?

9.1.4. In-depth analysis of various but independent mental health problems.

This research identified a few key findings related to how parole board members draw upon and understand mental health. First, future research will benefit from examining specific mental health problems such as Bipolar Disorder and Attention Deficit Hyperactivity Disorder (ADHD), perhaps in comparison to Borderline Personality Disorder particularly because these disorders include issues related to self-regulation, especially with regard to medication compliance. Although only a few references in my sample were noted, there was enough evidence to suggest that further research is needed to truly understand the impact of these disorders on decision-making.

Second, since neurological disorders such a FASD cannot be treated, and are managed through structure, it would be advantageous to examine if future research also finds that having a FASD or another organic brain disorder is deemed untreatable on the release process?

9.2. LIMITATIONS

This directed content analysis purposely sought out to examine mental health and diagnostic information. I am aware that simply because parole board members did not reference mental health does not suggest that the parole board member did not consider it. I can say the same of psychological assessments. There is simply so much data for a parole board member to review during the decision-making process. However, when referenced, the context provided some understanding of how parole board members understood the concept. This limitation leads me to my last point.

Due to my epistemological standpoint, my chosen method of inquiry did not examine the personal, heuristic biases as outlined in Chapter Three, within the psycho-cognitive section. This type of examinations, involving a mixed-method quantitative and further qualitative work, could further knowledge in this area. However, I believe that access to this type of research will remain a difficult hurdle as psychosocial research would involve individually interviewing parole board members, and this type of research would require permission from the PBC. Navigating access is not a very easy process for academics studying in the criminal justice field (Mopas and Turnbull 2011).

Finally, while not a limitation per se, I acknowledge that I rely on the label of offender throughout the dissertation. I wish to acknowledge the difficulty in coming to this decision; offenders are individuals whose life stories and strengths are often overlooked in favor of this master label. Inevitably, I succumbed to the path of least resistance. In order to remain consistent with my populations and differentiate the parole board member and the offender, I simply used the terminology consistent with the literature that I was drawing upon, i.e. the policy handbook; structured framework. As an aside, I do not differentiate much between the term prisoner and offender as they are both labels that tap into our understanding of someone incarcerated so this alternative was not an option for this research either.

9.3. POLICY IMPLICATIONS

According the Centre for Addictions and Mental Health Association (CMHA):

> Under the Ontario Human Rights Code, every person has a right to equal treatment with respect to services, goods and facilities, without discrimination. Discrimination is unfair treatment due to a person's identity, which includes race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability, including mental health disability. Acts of

> discrimination can be overt or take the form of systemic (covert) discrimination. (http://ontario.cmha.ca/mental-health/services-and-support/human-rights/)

I added this quote to raise an important policy implication. Based on this organizational statement and considering the findings here, does a re-conception of certain mental health problems as risk factors represent a systemic (covert) means of discrimination? If one were of the realist orientation, than this re-conceptualization is justifiable, at least in terms of public safety. I speak here of the category of mental health problems identified as aggravating factors, such as sexual deviance and/substance abuse.

As established in Chapter Five, correctional professionals are becoming more thorough diagnosing offenders at the intake stage of their sentence. However, I would argue that the manner in which the mental health information is reported, documented, and understood in parole decision-making is not so much set up to meet the needs of the offender, but the needs of the institution. Aside from acknowledging that offenders are managing their mental health, there was no evidence in parole board members' decision-making that demonstrate that they were attempting to meet the mental health needs of the offender. In fact, this research established how the role of the psychological expert, and by extension their psychological tools (i.e. actuarial tools), have been appropriated into the risk assessment process[88]. One could argue that this appropriation is contrary to the stated organizational priorities determined by the PBC and CSC, both of whom have committed to be responsive to the mental health needs of offenders:

> Policies, programs and legislation in the fields of mental health, mental illness and addiction are the responsibility of both provincial/territorial jurisdictions and the federal government and involve numerous departments and agencies. The organization, governance, funding and delivery of mental health services and supports and addiction treatment in Canada are

[88] Of course, the counter argument could be equally stated: Why would prisons and corrections cater to the needs of individuals? This has never been their social function and purpose to begin with.

> primarily the responsibility of provincial and territorial governments. Provinces and territories also govern mental health legislation in their respective jurisdictions[89].

Although parole board members are the last professionals in a long line of decision makers in the offender's file, I argue that parole board members still have an important role in ensuring that the offender being assessed for conditional release has had fair access to the appropriate mental health services and treatments. *Even if this means that the decision to release considers a release to community facilities in order to gain access to treatment programs.* Treatment options should be explored in parole decision-making, with stakeholders and other governmental agencies, to ensure that there are reasonable and fair options available to people who are seeking assistance in the treatment of their mental health needs.

In the current fiscal environment strapped for resources there still appears to be a genuine desire to address the problems associated with managing mental health within the correctional setting. However, PBC and their members should acknowledge their responsibility in this process. This would mean that each parole board member would need to examine, and take responsibility for, how their decision is either contributing (or not) to the problem of over-representation and criminalization of the mentally ill. For example, what if there were a genuine desire to seek treatment for their mental health problems, yet the offender was housed in a facility without the funding or capacity to meet the needs of the offender? What I know from this research is that through no fault of the offender, he would be unable to demonstrate that he could manage himself and this lack of treatment would reflect poorly in the decision-making process. The end result is that if the offender is identified as having a mental health problem yet does not have the opportunity to engage in self-

[89] http://www.parl.gc.ca/Content/SEN/Committee/381/soci/rep/report1/repintnov04vol1part3-e.htm

management efforts due to a lack of access to programs and treatments to address their mental health problems. This does not bode well for parole decision-making.

To come full circle, this dissertation highlights how law and policy influences parole board members' decision-making as it relates to mental health. Indirectly, this study may lend support for the differential treatment because, as I have demonstrated, parole board members may draw on mental health as a means to justify how an offender's mental health cannot be managed, therefore negatively impacting their access to the community. However, this study suggests that if the offender can demonstrate that they can manage or regulate their mental health, this is favourable to release. Overall, the differential treatment thesis does not account for these parallel processes. This dissertation has contributed to a better understand of the relationship between mental health and parole decision-making, and hopefully, provides a starting point for PBC to critically reflect on how their parole decisions reflect the government's commitment to meet the mental health needs of offenders.

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Appendix A : Ethics approval notice

File Number: 08-14-09 **Date (mm/dd/yyyy):** 09/08/2014

Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

Ethics Approval Notice

Social Sciences and Humanities REB

Principal Investigator / Supervisor / Co-investigator(s) / Student(s)

First Name	Last Name	Affiliation	Role
Ronald-Frans	Melchers	Social Sciences / Criminology	Supervisor
Shannon	Stewart	Social Sciences / Criminology	Student Researcher

File Number: 08-14-09

Type of Project: PhD Thesis

Title: Exploring how mental health problems are constructed in parole decision making

Approval Date (mm/dd/yyyy)	Expiry Date (mm/dd/yyyy)	Approval Type
09/08/2014	09/07/2015	Ia

(Ia: Approval, Ib: Approval for initial stage only)

Special Conditions / Comments:
N/A

550, rue Cumberland, pièce 154 Ottawa (Ontario) K1N 6N5 Canada
550 Cumberland Street, room 154 Ottawa, Ontario K1N 6N5 Canada
(613) 562-5387 • Téléc./Fax (613) 562-5338
www.recherche.uottawa.ca/deontologie/ www.research.uottawa.ca/ethics/

File Number: 08-14-09 **Date (mm/dd/yyyy):** 09/08/2014

Université d'Ottawa University of Ottawa
Bureau d'éthique et d'intégrité de la recherche Office of Research Ethics and Integrity

This is to confirm that the University of Ottawa Research Ethics Board identified above, which operates in accordance with the Tri-Council Policy Statement (2010) and other applicable laws and regulations in Ontario, has examined and approved the ethics application for the above named research project. Ethics approval is valid for the period indicated above and subject to the conditions listed in the section entitled "Special Conditions / Comments".

During the course of the project, the protocol may not be modified without prior written approval from the REB except when necessary to remove participants from immediate endangerment or when the modification(s) pertain to only administrative or logistical components of the project (e.g., change of telephone number). Investigators must also promptly alert the REB of any changes which increase the risk to participant(s), any changes which considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project and safety of the participant(s). Modifications to the project, including consent and recruitment documentation, should be submitted to the Ethics Office for approval using the "Modification to research project" form available at: http://www.research.uottawa.ca/ethics/forms.html.

Please submit an annual report to the Ethics Office four weeks before the above-referenced expiry date to request a renewal of this ethics approval. To close the file, a final report must be submitted. These documents can be found at: http://www.research.uottawa.ca/ethics/forms.html.

If you have any questions, please do not hesitate to contact the Ethics Office at extension 5387 or by e-mail at: ethics@uOttawa.ca.

Signature:

Kim Thompson
Protocol Officer for Ethics in Research
For Barbara Graves, Chair of the Social Sciences and Humanities REB

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Appendix B: Interview Guide

Thank you for agreeing to participate in this interview. As you know, I am conducting research for my PhD dissertation into the parole decision-making process, with a particular focus on how mental health problems are constructed in decision-making. I have asked for your participation because of your past history of working in the parole decision-making process, specifically as a decision maker. I have a few questions to ask you, please feel free to add any comments or suggest an alternative framing of the subject matter that may provide a more comprehensive understanding of how you made decisions when you were a parole board member. As you were informed in the information letter, you are not obliged to answer all the questions, and you can withdraw at anytime from this interview, without negative percussion. You will receive a copy of the transcribed notes within two weeks of our interview so that you may add, delete and/or comment further on any points therein. There are two sections to the questions, the first focuses on your personal characteristics and the second part will focus on the decision-making process you engaged in while you were a parole board member.

Participant # _____

Male/Female:

Age:

Length of time and Region you worked as a Parole Board Member:

Characterization or Area of Specialization in Career before and after your role as PBM:

Q1: Can you describe mental health and mental health problems? For example, are there specific acts, behaviours, patterns, and/or diagnoses that you recognize and interpret as a mental health problem?

1.1: Can you describe one or more cases that involved mental health problems?

Q2: Did you receive training related to mental health as a parole board member?

2.1: How did this training inform your decisions, thoughts, and understanding of mental health?

2.2: Can you describe a case in which your personal opinion of how to make a decision on a case was not consistent with regard to your training?

Q3: Can you discuss how mental health and risk relate to each other, if they do at all?

Q4: When you reviewed cases for parole release, were there any flags or concerns that would be raised by mental health problems? If so, could you provide your thoughts on how you would consider this information, if you did at all in your decision-making?

Q5: Can you describe how mental health may be favourable to a positive release decision? Any examples to share?

Q6: Are there cases in which mental health problems may negative impact on releasing an Offender(s)? Any examples to share?

Q7: Overall, can you discuss with me your thoughts about mental health and parole decision-making? Would you like to add any further comments regarding this subject?

Appendix C: Consent and Recruitment Letter

uOttawa

Université d'Ottawa | University of Ottawa

Département de criminologie | Department of Criminology

FSS 14002- 120 Université / FSS 14002 - 120 University, Ottawa, ON K1N 6N5

Dear XXXX,

Invitation to Participate: I am conducting research in the area of mental health and parole decisions. This letter serves as an invitation to participate in this research, as part of my doctoral degree in the Department of Criminology, Faculty of Social Sciences at the University of Ottawa, which is under the supervision of Professor Ron Melchers.

Purpose of the Study: The purpose of the study is to learn about how parole board members understand mental health as a factor for consideration in release decisions.

Participation: Your participation in the study is voluntary. It will involve an interview of approximately 30 minutes in length to take place at a place and time of your preference. The interview can also be conducted over the telephone if geographically a face to face interview is not viable. During the interview, you will be asked to discuss your opinions, understanding and issues you believe are considered in the decision-making process, in particular issues related to mental health and those behaviours and acts interpreted as mental health problems. You will be asked how you navigate through these issues during the decision-making process for release. You may decline to answer any of the interview questions. You may withdraw your consent at any time during the interview without any negative consequences from the researcher. As part of your consent, I would be permitted to audio record our interview to facilitate collection of data. I will later transcribe the tapes and provide you with a copy of the transcribed notes. This will provide you with an opportunity to review the notes from our interview to confirm the accuracy of our interview and to add or clarify any points further. All the information you provide will be considered confidential. Your name will not appear in any thesis resulting from this study. With your permission, anonymous quotations may be used. Data used in this study will be kept on file for up to 15 years after the study, in a locked filing cabinet in my personal residence and electronically on a password protected and locked computer. Only myself and researchers associated with this study will have access.

Risks and Benefits: There are little if any known risks associated with participation. Your participation entails volunteering information regarding how you made decisions while working in the capacity of a parole board member. You are fully entitled to answer only the questions you feel comfortable, and can stop the interview at any time. The benefits of the study will provide a better understanding into the decision-making process in parole decisions, in particular when mental health problems exist.

If you have any questions regarding this study, or would like additional information in order to make a decision in relation to your participation, please contact me at xxx-xxx-xxxx or by email, xxxxxx. You can also contact my supervisor, Professor Ron Melchers through his email, xxxxxx. I look forward to speaking to you with about this important subject and thank you in advance for your assistance in this project.

Shannon Stewart PhD Candidate, University of Ottawa

Consent Form

By signing this consent form, you are not waiving your legal rights or releasing the investigator(s) or involved institution from their legal and professional responsibilities. You are under no obligation to participate in this study. Should you choose to withdraw, your data will be destroyed and not used in the study.

I, _____ have read the information presented in the aforementioned information letter about a study being conducted by Shannon Stewart of the Department of Criminology, Faculty of Social Sciences, which is under the supervision of Professor Ron Melchers at the University of Ottawa. I have had opportunity to ask any questions related to this study, to receive satisfactory answers to my questions, and to add any additional details. I am aware that the notes of my interview will be transcribed and that excerpts from my interview may be included in the PhD dissertation and/or publications that transpires from this research. I understand that any quotations used in the research will be anonymous.

I was informed that I may withdraw my consent at any time without penalty by advising the researcher.

Acceptance:

With full knowledge of all foregoing, I agree to participate in this study conducted by Shannon Stewart of the Department of Criminology, Faculty of Social Science, which is under the supervision of Ron Melcher. I agree to the use of anonymous quotations in any of thesis or standard academic publications that comes of this research.

Further, if I have any questions I may contact the Protocol Officer for Ethics in Research at the following:

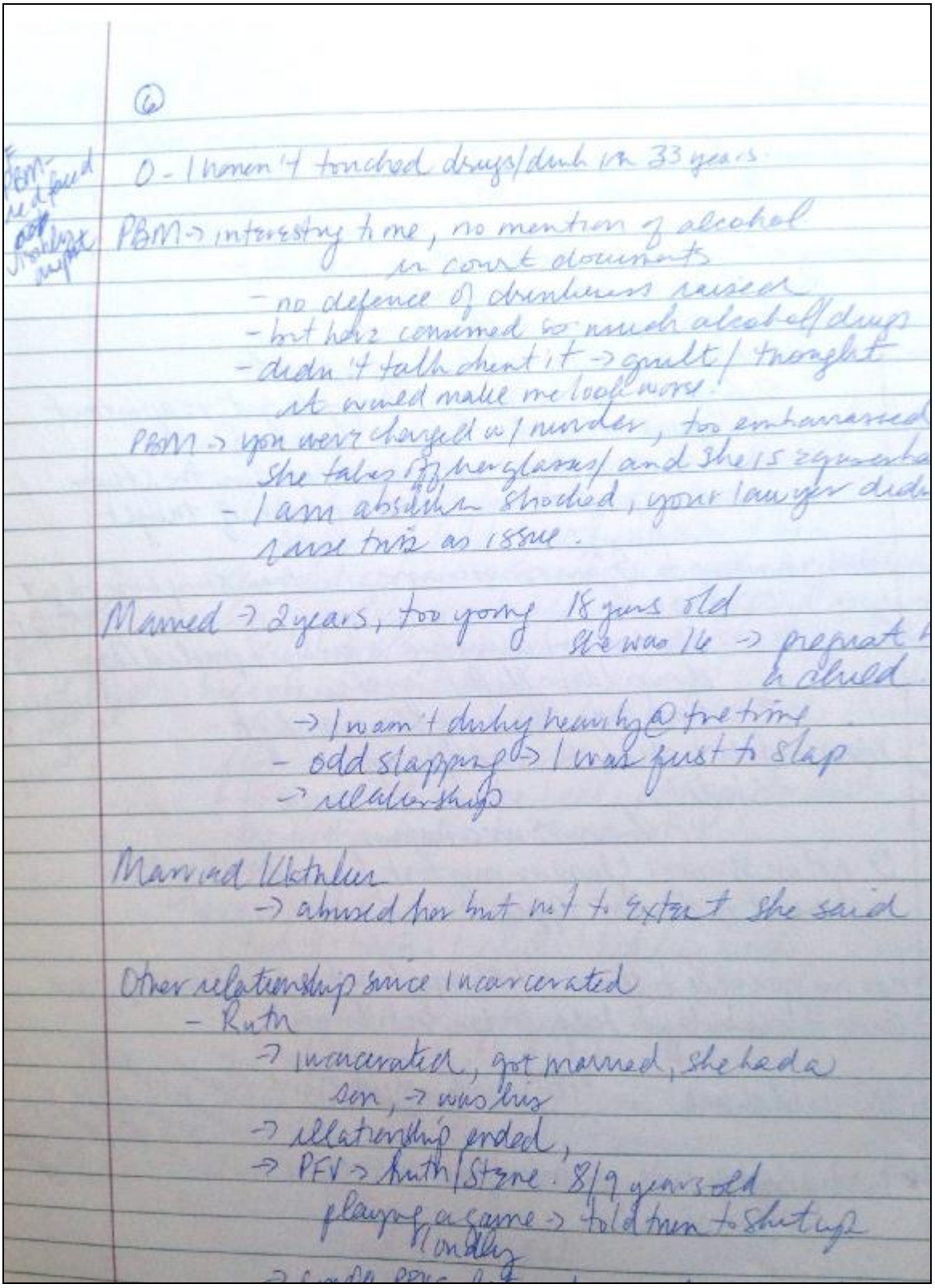
University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5 Tel.: (613) 562-5387, Email: ethics@uottawa.ca

There are two copies of the consent form, one of which is mine to keep.

Participant's signature: **Date:**

Researcher's signature: **Date:**

Appendix D: Coding of Field Notes



⑥

D - I haven't touched drugs/drunk in 33 years.

PBM → interesting time, no mention of alcohol in court documents
- no defence of drunkenness raised
- but he's crimmed so much alcohol/drugs
- didn't talk about it → guilt / thought it would make me look worse.

PBM → you were charged w/ murder, too embarrassed
She takes off her glasses/ and she is represented
- I am absolutely shocked, your lawyer didn't use this as issue.

Married → 2 years, too young 18 yrs old
she was 16 → pregnant & abused

→ I wasn't drunk nearby @ the time
- odd slapping → I was just to slap
→ relationship

Married Kathleen
→ abused her but not to extent she said

Other relationship since incarcerated
- Ruth
→ incarcerated, got married, she had a son, → was his
→ relationship ended,
→ PFV → Ruth Stone. 8/9 years old
playing a game → told them to shut up
Monday