

The Impact of Canadian Criminal Code Changes on Remands and Assessments of Fitness to Stand Trial and Criminal Responsibility in British Columbia

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Objective: To evaluate the impact in British Columbia of the 1992 Criminal Code of Canada amendments dealing with remands for fitness to stand trial and not criminally responsible on account of mental disorder (NCRMD) assessments.

Method: Information on 620 remands for evaluation of fitness to stand trial and/or NCRMD were collected from a sample obtained in British Columbia from 1992 to 1994. The data collected included length of remand order, length of evaluation, criminal charges, psychiatric diagnoses, and the decisions about fitness or NCRMD.

Results: Remands increased by about 20% in a 1993–1994 fiscal year compared with the previous year. The majority of evaluations continue to be conducted in an inpatient facility. The goal of a 5-day evaluation period is rarely met: only 12.5% of inpatients were released within 5 days of admission, and the average length of evaluation was about 3 weeks. The use and success of the NCRMD defence appears to be on the rise. In addition, there were some striking differences in remands from metropolitan and nonmetropolitan areas in terms of rates of referral and recommendations of unfitness or NCRMD.

Conclusion: Results indicated that Bill C-30 has not yet had the anticipated impact on remands as inpatient evaluations continue to be the norm and evaluations typically take several weeks. Suggestions for policy reform and future research are presented.

(Can J Psychiatry 1997;42:509–514)

Key Words: fitness to stand trial, forensic assessment, criminal responsibility

In Canadian criminal law and practice, the issue of mental disorder can be raised prior to trial if there are questions about a defendant's fitness to stand trial or criminal responsibility. If either or both issues are raised, a criminal defendant can be remanded for an evaluation of fitness to stand trial or criminal responsibility (1,2). The Criminal Code (3) places a

5-day limit on assessment orders unless the defendant and prosecutor agree to a longer period not exceeding 30 days. Compelling circumstances can extend this to a maximum of 60 days. These evaluations can take place in a jail, an outpatient clinic, or an inpatient facility.

Defendants are presumed fit to stand trial unless the court is satisfied on the balance of probabilities that they are unfit (4,5). The law defines unfitness as an inability, on account of mental disorder, to conduct a defence at any stage of the proceedings before a verdict is rendered or to instruct counsel to do so. An Ontario Court decision, *R. v. Taylor* (6), appears to narrow this definition. The Taylor decision held that the test to be applied in determining fitness is one of limited cognitive capacity. Briefly, it is only necessary that the defendant be able to recount to his or her attorney the necessary facts relating to the offence in such a way that the attorney can properly present a case. The Ontario Court of Appeal clearly indicated that it is not necessary that a defendant be able to act in his or her own best interests, presumably relying

Manuscript received July 1996, revised January 1997, and accepted February 1997.

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Table 1. Demographic characteristics

Characteristic	N	Type of evaluation			Overall
		Fitness	NCRMD	Both	
Mean age (years)	616	34.7	34.9	33.3	34.4
Men (%)	610	88.0	90.0	87.5	88.2
Single (%)	590	63.9	62.2	65.5	64.1
≤ Grade 10 (%)	590	39.6	36.6	48.6	41.4

on the attorney to ensure those interests are met. The Taylor decision may have an effect on the number of defendants found unfit because it appears to establish a lower minimum standard for fitness.

Section 16 of the Criminal Code (3) defines the law regarding the NCRMD defence. It holds that:

- 1) No person is criminally responsible for an act committed or an omission made while suffering from a mental disorder that rendered the person incapable of appreciating the nature and quality of the act or omission or knowing that it was wrong.
- 2) Every person is presumed not to suffer from a mental disorder . . . until the contrary is proved on the balance of probabilities.
- 3) The burden of proof . . . is on the party that raises the issue.

Until the 1992 Criminal Code changes took effect, defendants successfully raising this defence were confined automatically in an institution for an indeterminate period. In *R. v. Swain* (7), the Supreme Court of Canada held that this practice was unconstitutional. At the time of the Swain decision, approximately 1000 individuals who had been found not guilty by reason of insanity (NGRI) were being held under Lieutenant Governor's Warrants in Canada. In Swain, the Court provided for a 6-month period during which the Government of Canada was to pass legislation to correct the constitutional shortcomings of the current post-NGRI verdict procedures. In April 1992, Parliament passed Bill C-30. The new legislation has significantly changed the provisions for the evaluation and treatment of defendants who raise the insanity defence or fitness to stand trial issue in Canada. Some of the important highlights include limits on the length of remand for evaluation of fitness or insanity, changes to the disposition of an accused following a finding of NCRMD, changes regarding the parties who may raise the issue of the accused's insanity, and "caps" that have been placed on the maximum length of time a person may be detained following a finding of NCRMD. The capping provisions have not yet been proclaimed.

The purpose of the present study was to provide information on the processing of remands for fitness and NCRMD in British Columbia after the passage of Bill C-30. File information for remands over a 2-year period between 1992 and 1994 was collected.

Method

Files of defendants remanded for evaluations of fitness to stand trial and/or NCRMD in British Columbia were reviewed for the 1992–1993 and 1993–1994 fiscal years. There were 653 remands during this period. More remands were made in the 1993–1994 fiscal year ($n = 355$) than in the 1992–1993 year ($n = 298$), an increase of 19%. Of the 653 remands, 645 had been completed when data were collected. A further 10 participants were excluded from the analysis because their status changed to involuntary commitment under the Mental Health Act within a day of being remanded for evaluation; 15 were excluded because they had extremely long evaluations, most likely reflecting an error in record keeping (that is, changes in legal status were not recorded). The remaining 620 participants were used in subsequent analyses. The sample was divided into 3 groups: 1) fitness evaluation only, $n = 380$; 2) NCRMD evaluation only, $n = 91$; and 3) both fitness and NCRMD evaluations, $n = 149$. Information concerning the site of assessment was available for 599 of the remands: 88% ($n = 527$) were remanded to the Forensic Psychiatric Institute for inpatient evaluation, and the remaining 12% ($n = 72$) were remanded to one of several clinics for outpatient evaluation. For each remand, data concerning demographic information (age, sex, marital status, education), admission and discharge dates, type and length of court order, type of criminal charges coded according to the Criminal Code of Canada (3), psychiatric diagnosis (DSM-III-R Axes I and II; available only for the 1993–1994 participants), and length of evaluation were collected by 2 research assistants.

Results

Demographics of Cases

Table 1 presents the demographic characteristics of cases in the 3 groups. As is the case with most offenders on custodial remand in Canada (8), the majority of the referrals for psychiatric evaluation were single men; however, the psychiatric remands were older (mean age of about 34) and less educated (about 40% had no more than 10 years of formal schooling) than other nonpsychiatric custodial remands. There were no significant differences among the groups with respect to demographics. Overall, the sample was typical of Canadian psychiatric remands (9–11).

Remand and Evaluation Length

Table 2 shows the mean lengths of the initial remand order, the total remand (including any extension orders), and the total evaluation for the 3 groups. There was a consistent pattern for fitness-only remands to have shorter initial orders ($F[2,565] = 22.9, P < 0.001$) and shorter actual evaluations ($F[2,569] = 21.8, P < 0.001$) relative to both NCRMD-only remands and fitness-plus-NCRMD remands.

Figure 1 presents these data graphically. The horizontal axis represents time in days. The vertical axis represents the

Table 2. Mean length (in days) of initial remand order, total remand orders (including extensions), and actual evaluation

Remands and evaluations	Type of evaluation			Overall
	Fitness	NCRMD	Both	
Initial order (n = 566)	17.5	23.3	25.9	20.4
Total orders (n = 566)	21.5	26.7	35.7	25.7
Actual evaluation (n = 570)	16.5	22.6	26.2	19.7

Table 3. Source of remand

Source	Type of evaluation		
	Fitness (%)	NCRMD (%)	Both (%)
Metropolitan (n = 298)	219 (73.5)	38 (12.8)	41 (13.8)
Nonmetropolitan (n = 284)	144 (50.7)	42 (14.8)	98 (34.5)
Overall (n = 582)	363 (62.4)	80 (13.7)	139 (23.9)

Table 4. Mean length (in days) of remands and actual evaluations for inpatients from metropolitan versus nonmetropolitan areas

Source	Initial remand	Total remand	Evaluation
Metropolitan	13.5	20.1	19.4
Nonmetropolitan	27.2	29.3	22.9
Overall	20.3	24.7	21.1

cumulative percentage of cases whose remand or evaluation was shorter than or equal to that time. As the figure indicates, only about 25% of all remands and evaluations were for a period of about 7 days or less; about 50% were for periods between 14 and 21 days.

Remands and Evaluations by Region

In order to evaluate regional differences in the remand process, the referrals were divided into 2 groups according to whether they came from the metropolitan area in which the inpatient facility is located (that is, the lower mainland and Fraser Valley regions of British Columbia) or from other areas of the province (that is, the interior, northern, and Vancouver Island regions). As Table 3 indicates, just over half of the remands (298 of 582 cases or 51.2%) came from metropolitan areas. Interestingly, remands from nonmetropolitan areas were more likely to request both NCRMD and fitness evaluations than were those from metropolitan areas (34.5% versus 13.8%; $\chi^2[2, n = 582] = 38.8, P < 0.001$).

These analyses were based on the entire sample. We also examined differences between remands from metropolitan and nonmetropolitan areas for those defendants admitted for inpatient evaluation. Table 4 shows the mean length in days of the initial court order, the total remand (including extensions), and the actual evaluation for these cases. The mean initial remand ordered by nonmetropolitan courts was about 14 days longer than that ordered by metropolitan courts (complete data were available for 509 cases: $[F(1,507) =$

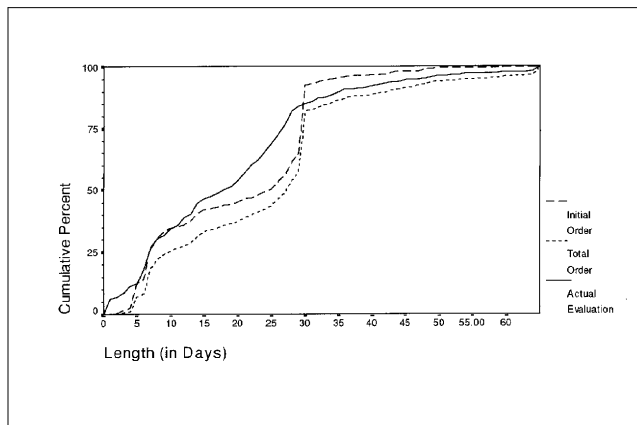


Figure 1. Length (in days) of initial remand order, total remand orders (including extensions), and actual evaluations.

254.6, $P < 0.001$]). Cases from nonmetropolitan courts were also about 9 days longer in total remand length (including extensions) ($F[1,507] = 41.1, P < 0.001$) and about 3 days longer in the actual length of the evaluation ($F[1,496] = 6.7, P < 0.05$). It appears that courts outside the lower mainland and the Fraser Valley routinely allow for longer remand periods. Of course, nonmetropolitan courts must allow extra time for the transportation of defendants; clearly, however, the differences observed were much too large to be explained solely by this factor.

Remand orders (including any extensions granted) set an upper limit on the length of evaluations; they do not provide a minimum length. In theory, the actual evaluation could take far less time than that provided for by the courts. In practice, however, this was not the case because the length of remands and the actual length of the evaluation were strongly correlated: for 523 cases, $r = 0.82, P < 0.001$. Controlling for type of remand made no significant difference (partial $r = 0.81, P < 0.001$).

Evaluation Recommendations

The evaluating psychiatrists made 754 recommendations concerning fitness and/or NCRMD. Although only 529 cases were remanded for fitness (including fitness-only and both fitness and NCRMD remands), psychiatrists made recommendations concerning fitness in 569 cases. The psychiatrists recommended that the majority of defendants were fit to stand trial ($n = 452, 79.4\%$). Only 92 cases (16.2%) were deemed unfit. For the remainder of the cases ($n = 25, 4.4\%$), either no specific recommendation concerning fitness was made or further evaluation was required.

Recommendations concerning NCRMD were made in 185 cases, although 240 cases were remanded for NCRMD (including NCRMD-only and both fitness and NCRMD remands). No specific recommendation was made concerning NCRMD in 19 (10.3%) of the cases. Either no specific evaluation was made, more time was required to complete the

evaluation, or a recommendation concerning fitness was made. The recommendation favoured NCRMD in 53 cases (28.6%). The remaining cases were recommended as not NCRMD ($n = 113$, 61.1%).

Psychiatrists' recommendations varied systematically according to whether the case was referred from metropolitan or nonmetropolitan areas. Of those cases referred to the Forensic Psychiatric Institute for inpatient evaluation of fitness, 260 (52.2%) came from metropolitan areas and 242 (47.8%) came from nonmetropolitan areas. As Table 5 indicates, only 72.4% of metropolitan remands were recommended as fit, compared with 87.2% of nonmetropolitan remands ($\chi^2[2, n = 474] = 16.3, P < 0.001$). Similar findings were obtained for NCRMD evaluations. The nonmetropolitan areas remanded more defendants for NCRMD evaluations than did the metropolitan areas, but nonmetropolitan remands were more likely to be recommended as not NCRMD ($\chi^2[2, n = 149] = 11.3, P < 0.005$).

Psychiatrists' recommendations concerning NCRMD also varied according to the fiscal year of remand. Remands during the 1993–1994 fiscal year were more likely to be recommended NCRMD than remands during the 1992–1993 fiscal year ($\chi^2[2, n = 185] = 32.3, P < 0.001$). There was no difference between the years with respect to recommendations of fitness.

Information concerning diagnosis was available only for remands made during the 1993–1994 fiscal year (Table 6). Psychiatrists' recommendations varied systematically according to diagnosis. Defendants diagnosed with a psychotic disorder were more likely to be found unfit than those diagnosed with other mental disorders, including major nonpsychotic mental disorders, minor nonpsychotic mental disorders, and substance abuse disorders, and those found not to have a mental disorder ($\chi^2[2, n = 308] = 52.7, P < 0.001$). The same pattern was found with recommendations concerning NCRMD, since defendants found to be NCRMD were more likely to be diagnosed with a psychotic disorder ($\chi^2[10, n = 104] = 31.0, P < 0.001$).

Type of Offence

A total of 1671 charges were laid against the 620 participants (Table 7). The majority of defendants (76.7%) referred had been charged with offences against persons. The 2 most frequent of these offences were assault, including aggravated assault and assault causing bodily harm (19.0%), and robbery (6.6%). Many of the nonviolent offences were trivial in nature; the 2 most common were property offences, including theft and break and enter (7.1%), and mischief (6.7%). There were no significant differences between the remanded subjects from metropolitan versus nonmetropolitan areas with respect to the charges laid against them.

Table 5. Psychiatrists' recommendations concerning fitness and NCRMD for remands from metropolitan versus nonmetropolitan areas

Region	Fitness		NCRMD	
	Fit (%)	Unfit (%)	Not NCRMD (%)	NCRMD (%)
Metropolitan	173 (72.4)	53 (22.2)	27 (50.0)	22 (40.7)
Nonmetropolitan	205 (87.2)	23 (9.8)	72 (75.8)	16 (16.8)

Row percents for fitness and NCRMD by region do not add to 100% because specific determinations of fitness or NCRMD were not made.

Table 6. Diagnosis by remand

Diagnosis	Type of evaluation			Overall (%)
	Fitness (%)	NCRMD (%)	Both (%)	
Anxiety disorders	0.6	0.0	0.0	0.6
Bipolar disorder	14.0	13.2	3.2	11.0
Depression	5.7	4.4	6.4	5.6
Paraphilia	0.5	0.0	2.1	0.8
Personality disorder	18.6	17.7	21.3	19.6
Schizophrenia	35.2	26.5	35.1	33.5
Substance abuse	9.8	10.3	12.8	10.7
No disorder	5.7	7.4	5.3	5.9

Discussion

An analysis of remand data for a 2-year period in British Columbia revealed a number of interesting results. First, the rate of remands may be on the increase, as the second year showed an increase of about 20% over the first year. Second, the majority of evaluations continue to be conducted in an inpatient facility. Third, the length of the evaluation period, particularly for inpatients, is substantially longer than the 5-day period indicated in Bill C-30. Fourth, there were some striking differences between remands from metropolitan and nonmetropolitan areas. Finally, the number of defendants who receive recommendations of NCRMD appears to be increasing.

Only 12% of the remands in our sample were sent to outpatient clinics, with the remainder sent to an inpatient forensic facility. It should be pointed out, however, that, at least in Vancouver, some assessments are conducted in the jails, and remands are avoided entirely. This in part accounts for the higher percentage of remanded subjects from the metropolitan region who were found unfit because defendants who were clearly fit to stand trial were screened at the jail level. The finding that a relatively small percentage of fitness remands were actually considered unfit, especially when remands from nonmetropolitan areas were examined, raises questions about the appropriateness of these referrals and points to the need for more adequate methods of screening defendants in the local community. Based on our finding

that only about 10% of nonmetropolitan remands were considered unfit, it appears that a substantial number of defendants are transported unnecessarily to an inpatient forensic facility for an evaluation. A large number of studies have demonstrated that community-based screening of fitness is both feasible and cost-effective (12–14). In contrast to the nonmetropolitan areas, it appears that the metropolitan area is doing a more adequate job of screening cases. We found that 22% of these referrals were considered unfit after the evaluations, suggesting that more of the referrals were made for cases in which unfitness was a real question.

Grisso and others (15) conducted a nationwide survey in the United States to determine how the states provided pretrial forensic evaluation services. They grouped the states into 5 system types that reflected different approaches to these evaluations (a few states could not be classified). The Traditional System (10 states) is characterized by a reliance on inpatient evaluations, usually in state hospitals, with evaluations conducted by multidisciplinary evaluation teams. The average time for completion of a report (from court order for an evaluation to the filing of a report) was about 27 days. The Private Practitioner System (9 states) relies on outpatient evaluations conducted by private practice mental health professionals. The average time for a report was 19 days. Community-Based Systems (11 states) also conduct outpatient evaluations but rely on mental health agencies or service-provider groups, including court clinics staffed full-time by forensic examiners. Inpatient evaluations are used in a minority of cases. The average time for a report was 27 days. The Modified Traditional System (5 states) uses central facilities, largely state hospitals, for conducting evaluations, but the emphasis is placed on outpatient evaluations. All of these states have provisions for inpatient evaluations, usually at the same site. The average time for a report within this system was 49 days. Finally, 8 states use a Mixed System, a combination of inpatient and outpatient evaluations in relatively equal proportions. Grisso and others found that the average report time in this system was 21 days for inpatient evaluations and 23 days for outpatient evaluations. When Grisso's classification of systems is applied to our study in British Columbia, it appears from our data that the nonmetropolitan areas are basically relying on a traditional system to conduct pretrial evaluations. The average length of the evaluation is comparable to the length reported in the American study (15). In contrast, the metropolitan area seems to be more proficient at screening cases, and those defendants who are remanded to the inpatient facility are kept for slightly shorter periods. This may in part be due to the fact that the 2 principal pretrial facilities in the lower mainland have formal jail mental health programs (16).

It appears that the goal of a 5-day remand was infrequently met, as only about 12.5% of evaluations were completed within this period. This finding is consistent with other studies of the impact of Bill C-30 (17). We recommend more research

Table 7. Type of offence by remand

Type of offence	Type of evaluation			Overall (%)
	Fitness (%)	NCRMD (%)	Both (%)	
Arson	2.6	8.8	5.4	4.2
Assault	36.8	47.3	42.3	39.7
Breaches	6.3	5.5	8.1	6.6
Driving offences	3.4	6.6	4.7	4.2
Escape	8.7	11.0	8.7	9.0
Fraud	3.9	4.4	1.3	3.4
Major sex offence	6.1	5.5	9.4	6.8
Minor sex offence	3.2	2.2	5.4	3.5
Murder	4.2	5.5	13.4	6.6
Property	18.4	9.9	18.1	17.1
Public mischief	19.5	16.5	16.1	18.2
Robbery	4.7	5.5	6.7	5.3
Threatening/ harassment	8.7	16.5	18.1	12.1

to determine why this has occurred, and we suggest including interviews with judges, forensic evaluators, and defence and crown attorneys to obtain their perspectives. We have conducted such a study with a number of key people involved in the remand process in British Columbia. The results of this study can be found in a report submitted to the Department of Justice and is available from the first author.

Remands for NCRMD evaluations were, as expected, less frequent than remands for fitness evaluations. In the past, prior to the Criminal Code (3) changes, it was uncommon for an NCRMD defence to be supported. The current study suggests that recommendations of NCRMD are on the rise. Indeed, while there were only 4 cases in which the evaluation supported such a defence in 1992–1993, there were 49 cases in 1993–1994. This means that 45% of the NCRMD evaluations in 1993–1994 resulted in a supportive evaluation report to the court. We do not know at this point whether the courts agreed with the evaluation recommendation, so the actual success of the defence could be lower, although prior research has shown consistently high rates of agreement between evaluators and the courts (18). Nevertheless, it appears that the success rate of the NCRMD defence, at least at the evaluation stage, may be increasing.

In summary, this study provides a picture of the remand process in one province in the 2-year period following the passage of Bill C-30. Ongoing research should be conducted to continue to monitor this process as well as to examine the feasibility of alternative methods for evaluating the issues of fitness and criminal responsibility, such as brief screening interviews (19). Also, we do not have any data on the treatment of unfit defendants and those found NCRMD. Since

the new legislation included major changes in the procedures regarding treatment, it will be useful to track cases from remand through to final disposition.

Clinical Implications

- The number of remands for pretrial evaluations appears to be on the rise.
- Inpatient evaluations continue to be the norm; only 12% of remands are evaluated on an outpatient basis.
- The average evaluation takes about 3 weeks, much longer than the 5-day period suggested by the 1992 Criminal Code revisions.
- The percentage of NCRMD remands resulting in recommendations of NCRMD also appears to be on the rise.

Limitations

- Data were available for only a 2-year period; additional data are needed to determine if the trend continues.
- No court outcome information was available, so we do not know the extent of agreement between the evaluators' recommendations and court decisions.

Acknowledgements

This research was supported by the Department of Justice, Government of Canada (contract 19081-2 C234-00-1). The authors wish to thank John Fleishman for his input into the design of the study, Derek Eaves for providing access to file information and for his support of this research, and Faye Grant for facilitating the collection of file data from the Forensic Psychiatric Institute and the clinics.

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Résumé

Objectif : Évaluer l'incidence, en Colombie-Britannique, des modifications apportées en 1992 au Code criminel du Canada en matière de renvois en vue d'évaluations pour déterminer l'aptitude à subir son procès et la non-responsabilité criminelle pour cause de troubles mentaux (NRCCTM).

Méthode : On a extrait des renseignements sur 620 renvois en vue d'évaluer l'aptitude à subir son procès et (ou) la NRCCTM d'un échantillon recueilli en Colombie-Britannique de 1992 à 1994. Les données rassemblées comprenaient la durée de l'ordonnance de renvoi, la durée de l'évaluation, les accusations au criminel, les diagnostics psychiatriques et les décisions à l'égard de l'aptitude ou de la NRCCTM.

Résultats : Les renvois ont augmenté d'environ 20 % pendant l'exercice 1993-1994 par comparaison avec l'année précédente. La majorité des évaluations continue d'être effectuée dans des établissements hospitaliers. On atteint rarement l'objectif d'une période d'évaluation de 5 jours : seulement 12,5 % des patients hospitalisés ont reçu leur congé dans les 5 jours suivant leur admission, et la durée moyenne d'évaluation était d'environ 3 semaines. Le recours à une défense fondée sur la NRCCTM et la réussite de celle-ci semblent être à la hausse. De plus, les renvois présentent des différences frappantes en matière de taux de remises et de recommandations d'inaptitude ou de NRCCTM, selon qu'ils proviennent de régions métropolitaines ou non.

Conclusion : D'après les résultats, le projet de loi C-30 n'a pas encore eu l'incidence prévue sur les renvois puisque les évaluations de patients hospitalisés sont toujours la norme et que les évaluations durent habituellement plusieurs semaines. On présente des propositions de réforme des politiques et de recherche à mener ultérieurement.