Public Attitudes and Perceptions toward the NCRMD Defense

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Abstract

In Canada today, a person who performs an illegal act that is deemed to be the result of a mental illness is eligible for the not criminally responsible on account of mental disorder (NCRMD) defense. This defense can remove the blame and responsibility from an individual for an act that would otherwise be considered criminal. The present study examines possible factors that may influence people's opinions on the defense and the treatment of mentally ill offenders in general. A sample of 257 participants (190 women, 38 men, 29 gender unknown) with ages ranging from 18-73 (M = 26.59, SD = 12.59) completed an online survey that assessed attitudes, opinions, and knowledge of mental illness, mentally ill offenders, and the NCRMD defense. Results showed that several factors were related to how positive or negative participants considered the defense to be, including experience with mental illness or the justice system and knowledge of schizophrenia or the sentences associated with the NCRMD defense. Findings suggest education is important in attaining more positive views of mentally ill offenders and the NCRMD defense.

Public Attitudes and Perceptions toward the NCRMD Defense

In the not-so-distant past, there were no laws concerning the treatment of mentally ill offenders in Canada. However, with a growing atmosphere of discontent provoked by some highly public events, legislation regarding these offenders began to emerge. In Canada today, a person who performs an illegal act that is deemed to be the result of a mental illness is eligible for the not criminally responsible on account of mental disorder (NCRMD) defense. A successful NCRMD defense can remove the blame and responsibility from an individual for an act that would otherwise be considered criminal. In several countries outside of Canada, this defense is known as the more commonly recognized insanity defense or insanity plea. The procedures that must be followed for an individual to be found not criminally responsible on account of mental disorder, and each individualized treatment program, are very extensive and many safeguards have been put in place to help prevent misuse. Additionally, studies show that offenders with mental illnesses fare better if they stay within the health care system than if they are subjected to the criminal justice system (Dirks-Linhorst & Linhorst, 2012; Hiday, Wales, & Ray, 2013; Lim & Day, 2014; McNiel & Binder, 2007). That being said, mentally ill offenders are still very much present within the criminal justice system for a number of reasons. In spite of the generally positive outcomes associated with the current treatment of mentally ill offenders, Bill C-14 (previously called Bill C-54) was introduced in 2013 (Bill C-14, An Act to amend the Criminal Code and the National Defence Act [Bill C-14], 2014). The purpose of the Bill is to make several changes to the ways in which individuals who are found not criminally responsible on account of mental disorder are handled (Bill C-14, 2014). It has been argued that the proposed amendments would be

detrimental to the justice system and to the overall treatment of mentally ill offenders. Perhaps the Bill is the result of a lack of public knowledge toward individuals with mental illnesses, a lack of knowledge toward the NCRMD defense, or both. The fostering of inaccurate beliefs could be contributing to unjustified negative attitudes, which might account for a portion of the reasoning as to why Bill C-14 is currently being debated.

Legislation of Mentally Ill Offenders in Canada: A Brief History

Before the 1800s, there was no government legislation in Canada that dealt with mentally ill offenders, or "insane" offenders, as they were known at the time (Pozzulo, Bennell, & Forth, 2015). Instead, these "insane" offenders were typically sent home and their families were instructed to look after them. Eventually, it was two cases in Britain that led to changes in the handling of offenders with mental illnesses in many parts of the world, including in the United States, England, and Canada (Moran, 1985).

The first of the two pivotal British cases was that of James Hadfield in the year 1800. James Hadfield was caught in an attempt to assassinate King George III, but he had previously suffered a brain injury in battle (Moran, 1985). His lawyer argued that he was "insane" at the time of the offense and the court came to the verdict that this was, in fact, true (Moran, 1985). Hadfield had to be set free, as there was a lack of legislation regarding "insane" offenders at the time. The freeing of Hadfield was dissatisfactory in the eyes of many individuals, as they believed the act of attempted murder of a king should surely be punished (Moran, 1985). As a result, the Criminal Lunatics Act (1800) was established, which, for the first time, enabled the government to detain "insane" offenders who committed serious crimes (Moran, 1985).

The second important case occurred in the year 1843. A man named Daniel McNaughton killed one of the then British Prime Minister's secretaries by shooting him in the back (Moran, 1985). He was charged with murder, but was found not guilty by reason of insanity (Moran, 1985). Criteria relevant to the insanity plea were outlined during this case. It was determined that in order to be considered "insane" in the eyes of the court, the defendant must be found to be suffering from a defect of reason or disease of the mind, the defendant must not know the nature or quality of the act he or she was performing, and the defendant must not know that what he or she was doing was wrong (Pozzulo et al., 2015). These three constructs quickly found their way into the Canadian justice system, and they are required as part of the NCRMD defense today (Pozzulo et al., 2015). The laws governing "insane" offenders changed very little following the case of McNaughton. If an individual were found not guilty by reason of insanity, that person would be automatically confined within an institution for some undetermined length of time (Ogloff & Schuller, 2001). Unfortunately, this approach was centered on managing the offenders, not treating them. The system was widely regarded as inadequate and some people argued that detaining mentally ill individuals for unfixed amounts of time was infringing on their basic human rights (Ogloff & Schuller, 2001).

With a widespread dissatisfaction toward the way "insane" offenders were handled and the subsequent emergence of Bill C-30 in 1992, the Canadian standard changed (Pozzulo et al., 2015). It was with this bill that Canada dropped the term not guilty by reason of insanity in favour of the more socially acceptable term not criminally responsible on account of mental disorder that is used today (Pozzulo et al., 2015). The Criminal Code of Canada was amended to included the following statement in section 16:

"No person is criminally responsible for an act committed or an omission made while suffering from a mental disorder that rendered the person incapable of appreciating the nature and quality of the act or omission or of knowing that it was wrong" (Pozzulo et al., 2015, p. 226). Also, with Bill C-30 came the establishment of review boards, which were appointed the duty of determining the appropriate disposition for each mentally ill offender, as well as reevaluating each offender from time to time (Pozzulo et al., 2015).

Since the enactment of Bill C-30, there have been slight alterations. For example, in 1999, the Supreme Court of Canada stated that any offenders who have been determined not criminally responsible on account of mental disorder should not be detained unless they are considered a danger to the public (Pozzulo et al., 2015). Also, reviews of the Canadian justice system in regard to mentally ill offenders took place in 2002 and 2007 in attempts to improve upon the legislation and make the general public more safe, while providing mentally ill offenders with the most beneficial and appropriate treatment (Pozzulo et al., 2015).

The Current Legislation

In order to be considered for the NCRMD defense today, the defendant must be found to have a mental disorder that was severe enough at the time to impact his or her knowledge of the nature and quality of the act performed, and the defendant must also have been unaware of the wrongfulness of said act (Pozzulo et al., 2015). These current requirements demonstrate the undeniable impact of the McNaughton case. In order to determine the mental state of the defendant at the time of the offense, qualified personnel must complete a psychological assessment (Pozzulo et al., 2015). Typically included in this assessment is the Rogers Criminal Responsibility Assessment Scales (R-CRAS)

(Pozzulo et al., 2015). This psychological test examines five different facets: patient reliability, organicity (possible biological underpinnings to abnormal behaviours), psychopathology, cognitive control, and behavioural control (Pozzulo et al., 2015). As with any psychological assessment, the clinician must take everything into consideration, from the R-CRAS scores to the physical presentation of the defendant, before making a final decision on criminal responsibility (Pozzulo et al., 2015).

In cases where a NCRMD defense is successful, different options are considered in regard to the treatment of the defendant, based on his or her current mental state and an evaluation of the level of threat the defendant presents to the public (Pozzulo et al., 2015). The defendant may be granted an absolute discharge, meaning he or she is released without restrictions (Crocker, Nicholls, Charette, & Seto, 2014; Pozzulo et al., 2015). This occurs in cases where the criminal behaviour is reasonably determined to be an isolated incident resulting from a severe episode of the mental illness and should not happen again as long as the individual receives the proper treatment (Crocker et al., 2014; Pozzulo et al., 2015). Alternatively, the defendant could be granted a conditional discharge, where he or she is released from custody but must meet certain conditions and is monitored to ensure these conditions are upheld (Crocker et al., 2014; Pozzulo et al., 2015). The restrictions put into place during a conditional discharge typically include such things as not possessing firearms or not possessing any type of drug or pharmaceutical that was not properly prescribed (Crocker et al., 2014; Pozzulo et al., 2015). Finally, in cases where discharging the defendant is not deemed a responsible action, the defendant may be admitted to a psychiatric facility (Crocker et al., 2014; Pozzulo et al., 2015). This typically occurs when the defendant is still considered to be a

risk to him or herself, or to others, as a result of severe, ongoing symptoms of the mental illness (Crocker et al., 2014). The current NCRMD defense requires the disposition to be the "least onerous and least restrictive" for the defendant (Crocker et al., 2014, p. 579). This means that if there is no proper evidence to suggest that the defendant will reoffend or be a danger to the self or others, the court must grant the individual an absolute discharge (Crocker et al., 2014). It is only if there is an indication of the defendant's prospective threat that the court can sentence the individual to a conditional discharge or to institutionalization (Crocker et al., 2014). Of course, the extent to which the defendant is deemed dangerous or shows persisting signs of the mental illness is the determining factor for which of the latter two dispositions is decided upon.

Except in the case of an absolute discharge, review boards continually assess the condition of the defendant to determine appropriate further action (Pozzulo et al., 2015). In Canada, these boards consist of a minimum of five individuals who are appointed provincially by the lieutenant governor of each province (Criminal Code, R.S.C., 1985, c.46, s.672.38). One member must be a registered psychiatrist and a second member must have training and experience in the field of mental health (Criminal Code, R.S.C., 1985, c.46, s.672.39). The chairperson of the board must be a judge, a retired judge, or somebody who is qualified to be a judge (Criminal Code, R.S.C., 1985, c.46, s.672.4). They are required to meet at least once per year to review each case of NCRMD (Pozzulo et al., 2015). In terms of a mentally ill offender's disposition, the review board takes into consideration many different facets. Public safety is an important factor for review boards (Pozzulo et al., 2015). They have to ensure that they are not allowing an offender to reenter the general public if there is a risk of reoffending. Closely related to this is the

mental state of the defendant (Pozzulo et al., 2015). If the defendant is experiencing clear psychotic symptoms, proper treatment must be provided immediately. Alternatively, if the defendant is deeply affected by the realization of what he or she did, there may be a risk to the self, which must be addressed. The main goal of the system is to rehabilitate mentally ill offenders and ensure they receive the proper treatment, therefore decreasing the likelihood that these individuals will go on to commit further offenses and increasing public safety (Pozzulo et al., 2015).

An important development for the treatment of mentally ill offenders has been the emergence of mental health courts. The main goal of these courts is to keep mentally ill offenders in the mental health system and out of the prison system (Hiday et al., 2013; Pozzulo et al., 2015). Mental health courts attempt to rehabilitate offenders instead of punish them, and they also place a lot of emphasis on proper assessment and treatment (Hiday et al., 2013; Pozzulo et al., 2015). Mental health courts also do their best to ensure that mentally ill offenders experience a smooth integration back into society (Hiday et al., 2013; Pozzulo et al., 2015). Some individuals do not need much guidance after they are released. They have homes and strong support systems. Others need much more guidance. Depending on the specific person in question, mental health courts may provide clothing, find somewhere for the individual to stay, and/or put into place an extensive treatment plan that may or may not include providing consistent outpatient care (Hiday et al., 2013; Pozzulo et al., 2015). In order for the courts to be able to provide these things, they commonly team up with a variety of community organizations and the rehabilitation of mentally ill offenders is typically seen as a community effort (Hiday et al., 2013; Pozzulo et al., 2015).

Mentally Ill Offenders in the Criminal Justice System

Not every mentally ill offender is successful with a NCRMD defense and not all offenders with mental illnesses attempt such a defense (Pozzulo et al., 2015). A notable percentage of individuals who are in the criminal justice system have some sort of mental illness (Bland, Newman, Dyck, & Orn, 1990). Many people within the general public assume that the high rate of mental illness in the prison system is due to the fact that individuals with mental illnesses are more likely to participate in illegal activities. However, there have been a number of proposed explanations to suggest that this finding is not so clear-cut (Bland et al., 1990).

One explanation for the high rate of mental illness in the prison population is that individuals with mental illnesses may be more likely to be arrested for their crimes than individuals who do not have a mental illness (Bland et al., 1990). For example, a police officer might be more willing to let a person off with a warning for a petty crime when that person seems to be otherwise healthy, rather than if the person is showing clear signs of mental illness. This could be the result of an officer perceiving that the mentally ill offender is a threat to him or herself, or a threat to public safety. This could also be the result of stigma toward mental illness.

A second explanation proposed for the large numbers of individuals with mental illnesses in the prison system is that these individuals may be more likely to get caught (Bland et al., 1990). This could unfold in a number of ways. For instance, an individual with a severe mental illness might not be able to commit a certain crime because he or she is unable to effectively plan the operation beforehand (Bland et al., 1990). Alternatively, the individual might be able to devise a sound plan, but he or she may have

a problem with the actual implementation of said plan (Bland et al., 1990). Also, depending on the disorder, the individual might not even be aware that he or she is committing a crime and in this circumstance the offender would probably not even try to hide his or her behaviour.

A third and final explanation for the large proportion of mentally ill offenders in the prison system is that these individuals may be more likely to plead guilty (Bland et al., 1990). This could be due to a larger proportion of mentally ill defendants who cannot afford, or who do not have access to, good representation in court in comparison to defendants without mental illnesses (Bland et al., 1990). Also, a mentally ill offender might not fully comprehend the consequences of pleading guilty, and therefore elect to do so (Bland et al., 1990). Basically, this explanation suggests that individuals with mental illnesses may be more likely to receive a guilty verdict than individuals without mental illnesses, not that individuals with mental illnesses actually commit more crimes.

Bill C-14

As previously mentioned, the current laws regarding the NCRMD defense may be changing quite soon. Bill C-14, known as the Not Criminally Responsible Reform Act, is a bill that aims to change how mentally ill offenders are dealt with (Bill C-14, 2014). It removes the "least onerous and least restrictive" requirement when deciding on the appropriate disposition, it creates a separate category of mentally ill offenders who are considered "high risk", and it adds new procedures that require victims and/or victims' families to be notified when defendants are discharged (Bill C-14, 2014).

If Bill C-14 is passed, it is expected that more mentally ill offenders will be tried and sentenced in the criminal courts instead of the mental health courts. This could be

detrimental as it has been found numerous times that mentally ill offenders who have been part of the mental health court system have a lower recidivism rate than mentally ill offenders within the criminal court system, meaning they are less likely to commit any further crimes (Dirks-Linhorst & Linhorst, 2012; Hiday et al., 2013; Lim & Day, 2014; McNiel & Binder, 2007). As a result of the changes the Bill aims to make, the justice system will no longer consider what is best for the mentally ill defendant, but more so what is best for society. Mentally ill offenders could potentially be placed in more generalized prison facilities where they may or may not receive treatment for their disorders. It could be argued that increasing the number of mentally ill offenders in the mainstream prison system would do nothing to combat recidivism, would possibly result in an increase in prison violence, and would fundamentally be a waste of taxpayer dollars. Additionally, and perhaps most importantly, individuals who were unaware of their actions at the time the wrongful act was committed, and who have no desire to engage in criminal behaviours once they are properly treated, are essentially being punished for acts that were outside of their control.

It is a strong possibility that the proposed changes to the Canadian standard have been fuelled by a surge of highly publicized instances of violent crimes committed by individuals with mental illnesses within the last decade, including the high profile case of Vince Li in 2008. It seems that these exceptional cases have led to public outcry and a seemingly far-reaching dissatisfaction with the system that is currently in place. It would be a major concern if Bill C-14 were, in fact, the result of public outcry and not the result of systematic research. If the Bill was proposed as a means to please the uneducated public and not for the purpose of actually improving the treatment of mentally ill

offenders, there is a strong chance that the implementation of the Bill will do more harm than good.

Public Knowledge and Attitudes

Schizophrenia

The proposition of Bill C-14 might be partially due to an inadequate understanding of the particular mental illnesses that are most commonly seen in a defense of NCRMD, which are schizophrenia and bipolar disorder. For the purpose of this study, schizophrenia will be the focus. Schizophrenia is defined as a psychotic disorder that involves disturbance of thought, emotion, and/or behaviour (American Psychiatric Association, 2013). In order to be diagnosed with schizophrenia, two or more of the following five criteria must be met: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behaviour, and negative symptoms (American Psychiatric Association, 2013). At least one of the symptoms must be delusions, hallucinations, or disorganized speech. In terms of negative symptoms, this could include lack of interest in routine behaviour, lack of speech or lack of content in speech, lack of interest in pleasurable activities, lack of interest in social interactions, or lack of emotional response and expression (American Psychiatric Association, 2013). Basically, a negative symptom is something that is not present in an individual, which is typically present in an otherwise healthy individual.

It is not an uncommon belief that people with schizophrenia are violent and dangerous (Angermeyer & Matschinger, 1996, 2003; Economou et al., 2012). While it is quite possible for a person experiencing severe symptoms of schizophrenia to become violent, it is not as common as many people think (Economou et al., 2012). The presence

of a split personality is also a common incorrect understanding that people have about individuals with schizophrenia (Economou et al., 2012; Leiderman et al., 2011). The confusion likely stems from the fact that the term "schizophrenia" comes from the Greeks roots *schizein* and *phren*, which translate to *split* and *mind*, respectively. However, a split personality is not a symptom of schizophrenia. Besides these two common incorrect perceptions, it has also been determined that members of the general public may believe that people with schizophrenia are incapable of keeping a job, yell incoherently in the streets and at strangers, have phobias, and have compulsions (Economou et al., 2012; Wahl, 1987). While it cannot be said that individuals with schizophrenia will never experience any of these things, they are not the common symptoms some members of the public believe them to be.

Not only do members of the general public associate schizophrenia with a list of incorrect symptoms, but they are also unaware of many of the actual symptoms of the disorder. For example, emotional blunting, disconnectedness, social withdrawal, and a lack of grooming and hygiene are all common in people with schizophrenia. Even so, these behaviours are not commonly considered by the general public to be symptoms of the disorder (Wahl, 1987).

There is a lot of stigma associated with mental illness, and schizophrenia may very well be one of the most stigmatized disorders today. This could largely be due to the inaccurate information that is so common within the general public. There is an extremely high rate of people who prefer not to interact or associate with individuals with schizophrenia at all (Eack, Newhill, & Watson, 2012; Economou et al., 2012; Leiderman et al., 2011). By avoiding contact with these individuals, people are not exposed enough

to learn the truth behind the disorder. In other words, stigmatizing schizophrenia leads to avoiding contact with individuals with schizophrenia, which further contributes to the stigma. In order for the cycle to be broken, something must be done. Thankfully, there have been studies to suggest that educational programs that aim to expose the truth and debunk the myths of schizophrenia can lead to a major increase in knowledge toward the disorder as well as a large decrease in negative attitudes and stigma (Eack et al., 2012; Economou et al., 2012). This is a very important finding. It suggests that negative opinions toward mental illness may be driven by inaccurate knowledge. Therefore, education might be the key to reducing stigma. By decreasing stigma toward schizophrenia and mental illness, stigma toward mentally ill offenders should also naturally decrease.

Treatment of Mentally Ill Offenders

Besides inadequate knowledge and negative attitudes toward schizophrenia, Bill C-14 might be a result of inadequate knowledge and negative attitudes toward the treatment of mentally ill offenders. Studies looking at public opinion and beliefs toward the NCRMD defense have yet to be completed. That being said, the insanity defense in locations outside of Canada has received much more attention in terms of research. There seems to be some widespread, yet inaccurate beliefs toward the insanity defense. First of all, many individuals believe that the defense is overused and that too many people get away with their crimes because they successfully plead not guilty by reason of insanity (Schlumper, 2011). This could likely be due to inaccurate portrayals of the insanity plea in the media. In actuality, the defense is used quite sparingly (Schlumper, 2011). While it is not necessarily uncommon for somebody to attempt the defense, only

a very small percentage of these defenses make it to trial (Schlumper, 2011). Furthermore, the safeguards and procedures put into place to assess an individual's criminal responsibility are very effective and it is a rare occurrence that somebody is inaccurately deemed not responsible by reason of insanity (Schlumper, 2011). Another common belief is that once a person is acquitted of a crime by reason of insanity, they are simply set free (Schlumper, 2011). In one study, three out of every four participants believed that once there is a verdict of insanity, the defendant is unconditionally released without any further consultation from mental health professionals (Schlumper, 2011).

Research looking at general attitudes toward the insanity defense exists, but little research has been completed recently. Findings from several decades ago suggested that the general attitude toward the defense was negative at the time (Hans, 1986). Furthermore, there was little to no relationship between attitudes toward the defense and basic demographic variables, such as age or gender (Hans, 1986). While these are important findings, it must be kept in mind that the attitudes today may be very different than the attitudes of almost 30 years ago. Also, it cannot be forgotten that the study in question focused on the insanity defense outside of Canada and that this type of research has not been thoroughly completed in regard to the NCRMD defense in Canada.

The Present Study

In light of the proposed changes to the current system, the purpose of the present study was to examine the knowledge of the general public about the current laws governing mentally ill offenders, as well as perceptions of how mentally ill offenders are treated. Past researchers have assessed aspects of public knowledge and attitudes toward the insanity defense, but the research is lacking in regard to the NCRMD defense. As a

result, determining the current attitudes toward perceived responsibility for criminal acts in Canada would provide valuable insight. Negative reactions to the current treatment of mentally ill offenders may be due to a lack of knowledge regarding mental illness itself or a lack of knowledge regarding the actual treatment of those who commit crimes while experiencing extreme symptoms of a mental illness. By looking at individuals from a wide range of demographics in the general population, a goal of this study was to determine whether or not certain groups could benefit from becoming more educated about the NCRMD defense and mental illness in general. A survey was developed to assess knowledge and attitudes toward the NCRMD defense. The Insanity Defense Attitude Scale-Revised (Skeem, Louden, & Evans, 2004) was included as part of the survey, with slight revisions to fit the Canadian terminology. Questions were added to assess a basic knowledge of schizophrenia as well as knowledge and opinions toward the current treatment of mentally ill offenders. Finally, demographic information was recorded in order to make comparisons between groups. A number of hypotheses were developed:

Hypothesis 1: It is commonly found that members of the general public regard people with schizophrenia as inherently dangerous and violent (Angermeyer & Matschinger, 1996, 2003; Economou et al., 2012). As a result of the negative beliefs about this mental illness, it was hypothesized that someone with schizophrenia will be seen as more responsible for committing a crime than someone without schizophrenia.

Hypothesis 2: NCRMD review boards consist of individuals with backgrounds in mental health (psychiatrists) and/or criminal justice (judges) (Criminal Code, R.S.C., 1985, c.46, s.672.39, s.672.4.). People with these qualifications are likely chosen due to the fact that

they possess a greater understanding of mental illness and the NCRMD defense. It was hypothesized that people who have knowledge of, or experience in, either the field of mental health or criminal justice will regard the defense as more positive than individuals without this experience.

Hypothesis 3: Hans (1986) found that the general attitude toward the insanity defense was negative. While this study was completed quite a while ago, opinions may not have drastically changed. It was hypothesized that the overall attitude toward the NCRMD defense in Canada would still be negative.

Method

Participants

A sample of 257 participants (190 women, 38 men, 29 gender unknown) was recruited from the participant pool at Grenfell Campus, Memorial University of Newfoundland as well as from the general population through an online survey. The participants ranged from 18-73 years of age (M = 26.59, SD = 12.59). These participants agreed to voluntarily complete a questionnaire assessing knowledge of, and opinions toward, the not criminally responsible on account of mental disorder (NCRMD) defense in Canada.

Materials and Procedure

Participants were given a link to an online survey (see Appendix A). First, participants read one of three short scenarios depicting a homicide (see Appendix B). All three scenarios consisted of a man named Sam who succumbed to a stab wound at the hands of an unnamed perpetrator. The scenarios differed only in the last sentence. The first scenario stated that the perpetrator had previously been diagnosed with schizophrenia, the second scenario stated that the perpetrator was recently prescribed an opiate that had a possible side effect of hallucinations, and the third scenario stated that the perpetrator had no history of mental illness and no drugs were found in his system. Participants were then asked a series of questions based on the scenario. The format of each of these questions was either a Likert scale or an open-ended question. For example, participants were asked, "How responsible for the stabbing is the man who killed Sam?" with possible answers ranging from 1 (*not at all responsible*) to 7 (*completely responsible*). Next, participants indicated how familiar they were with

selected terminology related to the NCRMD defense. These questions were of a Likert scale format, with answers ranging from 1 (*not at all familiar*) to 7 (*completely familiar*). Participants who indicated that they were somewhat familiar with a particular term were asked to describe what they believed that term meant in an open-ended response. For example, participants were asked, "How familiar are you with the term 'absolute discharge'?" Participants who answered 4 or greater were then asked the open-ended question, "To the best of your knowledge, what is an absolute discharge?" Participants who answered 3 or less were not asked the open-ended question, but proceeded to the next term. Next, participants were assessed on their knowledge of schizophrenia by indicating how often they believed certain traits or behaviours were indicative of schizophrenia using a Likert scale. For example, participants read the statement, "People with schizophrenia have split/multiple personalities" and then rated the likelihood of this statement being true on a scale from 1 (*never*) to 7 (*always*). Participants then completed the Insanity Defense Attitude Scale-Revised (Skeem, Louden, & Evans, 2004; permission for use was granted by the authors; see Appendix C). The scale consisted of a series of statements about the NCRMD defense and participants indicated the extent to which they agreed or disagreed with these statements using a Likert scale from 1 (*strongly disagree*) to 7 (*strongly agree*). Participants were then asked their opinion on the current treatment of mentally ill offenders in Canada. This was done in a similar format to the previous section, where participants indicated how much they agreed or disagreed with each statement using a Likert scale. For example, participants read the statement, "Mentally ill offenders should be handled by mental health professionals" and indicated their level of agreement from 1 (*strongly disagree*) to 7 (*strongly agree*). Finally, participants were

asked to indicate their age, gender, and any personal experience they had with either mental illness or the criminal justice system.

Results

This study was conducted to assess factors that potentially influence people's opinions of the treatment of mentally ill offenders and the NCRMD defense. Results are organized to first address differences in ratings of blame and potential use of the NCRMD defense across the three provided scenarios. Punishment suggestions provided by the participants are presented before an examination of whether experience with mental illness or the justice system had an impact on participants' perceptions of blame and the use of the NCRMD defense. Finally, factors influencing IDAR score are examined, including an assessment of the relationship between experiences with mental illness or the justice system and IDAR score as well as relationships between IDAR scores and knowledge of both schizophrenia and sentences commonly used as part of a NCRMD decision.

Scenario Questions

In order to determine whether there were differences amongst perceptions of a perpetrator with schizophrenia, a perpetrator under the influence of an opiate, and a perpetrator with no potential explanation for his crime, a MANOVA was completed with scenario as the between subjects variable and questions assessing perpetrator blame, victim blame, and potential use of the NCRMD defense as dependent variables. Results showed there was an effect of scenario to which participants were assigned, $F(10, 496) = 15.89$, $p < .001$; Wilk's $\Lambda = 0.57$, $\eta_p^2 = .24$. Follow-up ANOVAs with scenario as the between subjects variable and the different questions as dependent variables were then completed to assess where differences in perceptions existed. There was a significant difference in ratings of perpetrator responsibility, $F(2, 252) = 35.23$, $p < .001$, $\eta_p^2 = .22$.

Participants in the schizophrenia condition said the man was less responsible ($M = 4.59$, $SD = 1.83$) than participants in the control condition ($M = 6.54$, $SD = 1.03$; mean difference = 1.95, $p < .001$, 95% CI [-2.54, -1.36]) and participants in the opiate condition said the man was less responsible ($M = 5.04$, $SD = 1.85$) than participants in the control condition (mean difference = 1.50, $p < .001$, 95% CI [-2.10, -0.91]). There was no difference between ratings of perpetrator responsibility in the schizophrenia and opiate conditions.

There was also a significant difference across the three scenarios in the extent to which participants believed criminal punishment was necessary, $F(2, 252) = 34.71$, $p < .001$, $\eta_p^2 = .22$. Participants in the schizophrenia condition believed criminal punishment was less necessary ($M = 4.40$, $SD = 1.96$) than participants in the control condition ($M = 6.45$, $SD = 1.10$; mean difference = 2.05, $p < .001$, 95% CI [-2.66, -1.44]) and participants in the opiate condition believed criminal punishment was less necessary ($M = 4.99$, $SD = 1.86$) than participants in the control condition (mean difference = 1.46, $p < .001$, 95% CI [-2.08, -0.84]). There was no difference in ratings for participants in the schizophrenia and opiate conditions.

There was a significant difference across the three scenarios in participants' ratings of the likelihood the man would use the NCRMD defense, $F(2, 252) = 20.71$, $p < .001$, $\eta_p^2 = .14$. Participants in the schizophrenia condition believed the man was more likely to use the NCRMD defense ($M = 6.18$, $SD = 1.18$) than participants in the control condition ($M = 4.92$, $SD = 1.82$; mean difference = 1.26, $p < .001$, 95% CI [0.71, 1.80]) and participants in the opiate condition believed the man was more likely to use the NCRMD defense ($M = 6.19$, $SD = 1.36$) than participants in the control condition (mean

difference = 1.26, $p < .001$, 95% CI [0.71, 1.82]). There was no difference in perceptions of the likelihood of using the NCRMD defense in the schizophrenia and opiate conditions.

Lastly, there was a significant difference across the three scenarios in how successful participants believed a NCRMD defense would be, $F(2, 252) = 61.86$, $p < .001$, $\eta_p^2 = .33$. Participants in the schizophrenia condition believed a NCRMD defense would be more successful ($M = 5.44$, $SD = 1.18$) than participants in the opiate ($M = 4.82$, $SD = 1.43$; mean difference = 0.62, $p = .015$, 95% CI [0.09, 1.15]) and control conditions ($M = 3.14$, $SD = 1.58$; mean difference = 2.30, $p < .001$, 95% CI [1.78, 2.82]). Participants in the opiate condition believed a NCRMD defense would be more successful than participants in the control condition (mean difference = 1.68, $p = .015$, 95% CI [1.16, 2.20]).

Punishment Suggestions

When participants were asked to indicate the punishment to which they believed the perpetrators discussed in the assigned scenarios should receive, 118 believed punishment should come from the penal system, 34 believed the man should be institutionalized, 20 believed the man should receive therapy, and 35 suggested some combination of the three. Chi-square analyses determined that suggested punishment varied according to the scenario to which participants were assigned, $\chi^2(6, N = 207) = 62.26$, $p < .001$, $\phi^2 = .30$.

As seen in Figure 1, the suggested punishments varied according to the scenarios to which participants were assigned. More specifically, follow-up analyses using additional chi-squares showed the percentage of participants who suggested that a

suitable punishment should come from the penal system differed across scenario, $\chi^2(2, N = 118) = 23.71$, $p < .001$, $\phi^2 = .20$. Participants in the control condition were more likely to suggest a punishment using the penal system than participants in both the schizophrenia, $\chi^2(1, N = 81) = 22.83$, $p < .001$, $\phi^2 = .28$ and opiate conditions, $\chi^2(1, N = 99) = 6.31$, $p = .012$, $\phi^2 = .06$. Participants in the opiate condition were also more likely to suggest a punishment using the penal system than participants in the schizophrenia condition, $\chi^2(1, N = 56) = 5.79$, $p = .016$, $\phi^2 = .10$.

The percentage of participants who suggested a suitable punishment would be institutionalization also differed according to scenario, $\chi^2(2, N = 34) = 32.88$, $p < .001$, $\phi^2 = .97$. Participants in the schizophrenia condition were more likely to suggest institutionalization than participants in both the opiate, $\chi^2(1, N = 32) = 15.13$, $p < .001$, $\phi^2 = .47$ and control conditions, $\chi^2(1, N = 29) = 21.55$, $p < .001$, $\phi^2 = .74$.

Lastly, the percentage of participants who suggested therapy as a suitable punishment differed according to scenario $\chi^2(2, N = 20) = 7.60$, $p = .022$, $\phi^2 = .38$. Participants in the schizophrenia condition were more likely to suggest therapy than participants in the control condition, $\chi^2(1, N = 14) = 7.14$, $p = .008$, $\phi^2 = .51$.

Experience

In order to determine whether experience with either mental illnesses or the criminal/correctional justice system influenced participants' perceptions, additional MANOVAs were completed with responses regarding the scenarios as the dependent variables and both scenario and questions assessing varying types of experience (personal experience with mental illness, a degree in psychology, course work in criminal justice or corrections) as the independent variables. Results showed there was an effect of personal

experience with mental illness on participant responses, $F(5, 245) = 2.43$, $p = .036$; Wilk's $\Lambda = 0.95$, $\eta_p^2 = .05$. Follow-up ANOVAs with responses regarding scenarios as the dependent variables and both scenario and personal experience as the independent variables determined that there was a significant difference between participants who did and did not have personal experience with mental illness in ratings of perpetrator responsibility, $F(1, 249) = 10.09$, $p = .002$, $\eta_p^2 = .04$. Participants with no personal experience with mental illness believed the man was more responsible ($M = 5.67$, $SD = 1.76$) than participants with personal experience with mental illness ($M = 5.04$, $SD = 1.82$; mean difference = 0.64, $p = .002$, 95% CI [0.24, 1.03]).

Results of a MANOVA indicated that there was no effect of whether or not participants had completed or were completing a psychology degree on participant responses, $F(5, 245) = 1.57$, $p = .17$; Wilk's $\Lambda = 0.97$, $\eta_p^2 = .03$. However, as it was hypothesized that education would influence perceptions toward the NCRMD defense, further analyses were conducted. A series of ANOVAs with responses regarding scenarios as the dependent variables and both scenario and education in psychology as the independent variables determined that in terms of whether participants believed the man would use the NCRMD defense, there was a significant interaction between the scenario and whether or not participants completed or were completing a degree in psychology, $F(2, 249) = 5.03$, $p = .007$, $\eta_p^2 = .04$. Follow-up analyses showed participants' ratings of the likelihood of a NCRMD defense differed in just the control scenario, $F(1, 87) = 9.80$, $p = .002$, $\eta_p^2 = .10$. Participants who had completed or were completing a psychology degree believed it was less likely for the NCRMD defense to be used in this circumstance ($M = 3.85$, $SD = 1.66$) than participants without a background

in psychology, (M = 5.23, SD = 1.76; mean difference = 1.38, p = .002, 95% CI [0.51, 2.26]).

Similarly, results of a MANOVA indicated that there was no effect of whether or not participants had completed course work in criminal justice or corrections on participant responses, $F(5, 245) = 1.53$, $p = .18$; Wilk's $\Lambda = 0.97$, $\eta_p^2 = .03$. However, as it was again specifically hypothesized that education would influence perceptions toward the NCRMD defense, further analyses were conducted. A series of ANOVAs with responses regarding scenarios as the dependent variables and both scenario and course work in criminal justice or corrections as the independent variables determined that there was a significant difference between participants who had and had not completed course work that discussed criminal justice or corrections in ratings of perpetrator responsibility, $F(1, 249) = 6.19$, $p = .013$, $\eta_p^2 = .02$. Participants who had not completed this type of course work believed the man was more responsible (M = 5.55, SD = 1.67) than participants who had completed this type of course work (M = 5.00, SD = 2.05; mean difference = 0.55, p = .013, 95% CI [0.12, 0.99]).

IDAR Scores

A completely neutral score on the IDAR is 76.00. Scores higher than 76.00 indicate a more negative view of the NCRMD defense while scores lower than 76.00 indicate a more positive view of the defense. In the present study, the mean overall score on the IDAR was 66.73 (SD = 20.26). Independent-measures t-tests with different types of experience as the independent variables and IDAR score as the dependent variable were conducted to assess differences in IDAR scores as a result of experience with mental illness or criminal justice. Participants who had not completed or were not

completing a degree in psychology scored significantly higher on the IDAR (M = 68.74, SD = 19.30) than participants who had or were completing a degree in psychology (M = 61.22, SD = 21.93; mean difference = 7.51), $t(215) = 2.45$, $p = .015$, $r^2 = .03$, 95% CI [1.46, 13.57].

Similarly, participants who had not completed course work in criminal justice or corrections scored significantly higher on the IDAR (M = 67.77, SD = 19.70) than participants who had completed such course work (M = 55.89, SD = 23.28; mean difference = 11.87), $t(215) = 2.47$, $p = .014$, $r^2 = .03$, 95% CI [2.40, 21.35].

To further assess the relationship between scores on the IDAR and knowledge of mental illness, responses to items assessing knowledge of schizophrenia were correlated with IDAR scores. IDAR scores were positively correlated with participants' ratings of the likelihood of people with schizophrenia having split/multiple personalities, $r = .28$, $n = 216$, $p < .001$ and being dangerous and violent, $r = .22$, $n = 215$, $p = .001$, participants' opinions that mentally ill offenders should be handled by correctional employees, $r = .44$, $n = 213$, $p < .001$, participants' beliefs that once released back into the community, mentally ill offenders are not properly monitored, $r = .39$, $n = 213$, $p < .001$, and participants' opinions that mentally ill offenders should be imprisoned indefinitely, $r = .47$, $n = 214$, $p < .001$. As IDAR scores increased, participants were more likely to believe that people with schizophrenia had split/multiple personalities and were dangerous and violent, that correctional employees should handle mentally ill offenders, that mentally ill offenders are not properly monitored once released back into the community, and that mentally ill offenders should be imprisoned indefinitely. IDAR scores were negatively correlated with participants' ratings of the likelihood of people

with schizophrenia being treatable, $r = -.15$, $n = 215$, $p = .031$ and participants' opinions that mentally ill offenders should be handled by mental health professionals, $r = -.28$, $n = 212$, $p < .001$. As IDAR scores increased, participants were less likely to believe that schizophrenia could be treated and that mental health professionals should handle mentally ill offenders.

To assess whether participants' IDAR scores differed according to the punishment to which they believed an individual with schizophrenia should be assigned, those participants who completed that specific scenario were isolated. A one-way between subjects ANOVA was then completed with IDAR score as the dependent variable and the type of punishment participants assigned (penal system, institutionalization, therapy or some combination of the three) as the independent variable. There was a significant difference in IDAR scores across the four punishments participants provided, $F(3, 59) = 5.43$, $p = .002$, $\eta_p^2 = .22$. Participants who said a suitable punishment would be within the penal system had higher IDAR scores ($M = 78.63$, $SD = 21.79$) than participants who said a suitable punishment would be institutionalization ($M = 56.92$, $SD = 16.88$; mean difference = 21.71, $p = .004$, 95% CI [5.26, 38.16]) and participants who said a suitable punishment would be therapy ($M = 54.63$, $SD = 21.81$; mean difference = 24.00, $p = .026$, 95% CI [1.93, 46.07]).

When knowledge of sentences that are often used as part of a NCRMD decision were assessed, participants who indicated they were familiar with these sentences were not necessarily as knowledgeable as they assumed (see Figure 2). A regression analysis completed to determine whether IDAR score could be predicted using how much participants know about the actual sentences was significant, $F(1, 215) = 4.56$, $p = .034$,

R^2 = .02, suggesting more knowledgeable individuals had lower IDAR scores. The regression indicated predicted IDAR scores were equal to 68.68 – 3.88 (number of punishments correctly defined). IDAR scores would be expected to decrease by 3.88 for each punishment correctly defined.

Discussion

Historically, the policies regarding the treatment of mentally ill offenders in Canada have been subject to change. Bill C-14, the most recent proposition to amend the Canadian standard, may arguably have a very negative impact on the treatment of mentally ill offenders. It is likely that the emergence of the Bill may have been the result of public outcry due to stigma toward mental illness and a lack of knowledge of the current treatment of offenders with mental illnesses. The results from the present study offer some insight into public perceptions toward the NCRMD defense and the treatment of mentally ill offenders. While research has been previously completed to look at perceptions of the insanity plea in places outside of Canada, the NCRMD defense within Canada is a topic of much less research. That being said, the bases of the hypotheses of this study were rooted in research on the insanity plea, as it was expected that the public would look upon the NCRMD defense in the same general light.

Scenario Questions

Due to a lack of research assessing perceptions of criminal responsibility across different scenarios, the first hypothesis that someone with schizophrenia would be seen as more responsible for committing a crime than someone without schizophrenia was based on the common finding of generally negative attitudes toward schizophrenia (Angermeyer & Matschinger, 1996, 2003; Economou et al., 2012). However, this hypothesis was not supported. Opinions toward perpetrator responsibility, the necessity of punishment, the likelihood of a NCRMD defense, and the potential success of a NCRMD defense differed in regard to whether the perpetrator had schizophrenia, was under the influence of an opiate, or did not have a history of mental illness and was not

under the influence of a prescribed opiate. However, the differences were not as predicted. In the scenario where the perpetrator had schizophrenia, the perpetrator was seen as less responsible, punishment was seen as less necessary, and a NCRMD defense was seen as more likely to occur and more likely to succeed than in the scenario where the perpetrator did not have schizophrenia. A possible explanation for this finding is that even though many members of the public see people with schizophrenia as violent, they blame the violent behaviours on the illness itself instead of the person with the illness.

With the exception of the potential success of a NCRMD defense, there were no differences between these ratings between a perpetrator with schizophrenia and a perpetrator under the influence of a prescribed opiate. This is an important finding because it may show that even if the public is becoming more aware that an individual committing a crime as a result of severe symptoms of schizophrenia is very different from a person without schizophrenia committing a crime, a crime committed as a result of severe side effects of a prescribed opiate is not distinguished from a crime committed under more typical conditions.

Punishment Suggestions

Due to the fact that participants were less likely to suggest a punishment within the penal system for a perpetrator with schizophrenia than without schizophrenia, the first hypothesis was once again not supported. Participants were also more likely to suggest institutionalization or therapy for a perpetrator with schizophrenia than without schizophrenia. This finding provides further support that the public may see a person with schizophrenia who commits a crime as less responsible than a person without schizophrenia who commits the same crime. Participants in this study seem to be looking

at crimes committed as a result of mental illness as different from crimes committed for other reasons.

While these findings related to punishment suggestions can easily be interpreted in an optimistic manner, there is nevertheless much progress to be made. Several participants in the schizophrenia condition still suggested a punishment from the penal system or some combination of treatment alongside some punishment from the penal system. Furthermore, the suggested treatments for a perpetrator who committed a crime as a result of hallucinations from a prescribed opiate were notably harsh. In this situation, once the drug is discontinued, the hallucinations should stop immediately and should not return. Unlike in the case of a mental illness, where psychotic symptoms have to be continuously monitored and treated, psychotic symptoms would cease to be a risk if they were the result of a drug. Therefore, the ideal punishment suggestion in this case would, in fact, be no punishment at all. However, there were no participants who provided an answer to this question that stated a punishment was not necessary.

Experience

The second hypothesis that people who have knowledge or experience in either the field of mental health or criminal justice will regard the defense as more positive than individuals without this experience was very much supported in the present study. It was found that participants with experience with mental illness or experience in course work related to criminal justice or corrections believed the perpetrator was less responsible than participants without this experience. It was also found that participants with a psychology degree or experience with course work in criminal justice or corrections scored lower on the IDAR than participants without these experiences.

Participants with a degree in psychology understood that the NCRMD defense is not a commonly used defense and is not used without proper reason, indicating a more positive view of the defense. This finding is particularly interesting because one factor that contributes to negative perceptions toward the defense is the belief that it is overused and that otherwise healthy offenders use it to get away with their crimes (Skeem, Louden, & Evans, 2004). However, psychology majors are more aware that this is not the case.

High scores on the IDAR were correlated with level of agreement to negative or inaccurate statements regarding schizophrenia and mentally ill offenders. This also supports the second hypothesis as it suggests individuals with a greater knowledge of mental illness view the NCRMD defense as more positive. It was also found that individuals who did not possess any knowledge of common NCRMD dispositions had higher scores on the IDAR than individuals who were aware of these dispositions. In fact, the more NCRMD dispositions a given participant could accurately define, the lower his or her IDAR score was predicted to be.

An alarming finding regarding the NCRMD dispositions was the general lack of knowledge about them. The majority of participants were not familiar with at least some of the terms. Even more alarming was the fact that within the individuals who indicated they were familiar with, and therefore provided definitions of, the terms, the majority of the definitions were incorrect. This finding demonstrates that the there is a serious lack of public knowledge on what actually happens when a person is successful with a NCRMD defense. Even among just the people who believe they are adequately educated about the dispositions, a startling number either do not fully understand the terms or foster a supposed knowledge about the terms that is blatantly wrong.

IDAR Scores

The mean of the total scores on the IDAR was lower than the value that would indicate a neutral score, implying a slightly positive opinion on the NCRMD defense for these participants. This finding does not support the third hypothesis that the overall attitude toward the NCRMD defense in Canada is generally negative. The hypothesis was based on research of the insanity plea in the United States that was not completed recently (Hans, 1986). A plausible explanation for this finding could be that public perceptions toward the NCRMD defense in Canada are more positive than public perceptions toward the insanity defense in the United States. An alternative, and perhaps more likely, explanation is that attitudes toward these defenses have become more positive.

Implications

The main implication of the present study is that education is key to reduce negative attitudes toward the NCRMD defense and the treatment of mentally ill offenders in general. It has been suggested that the factors that seem to decrease IDAR scores and increase a more positive judgment of perpetrator responsibility and punishment suggestions are all related to attaining more accurate knowledge of all aspects of the NCRMD defense, from the illnesses involved to the possible NCRMD sentences.

A plausible explanation to why individuals with a psychology degree have a more positive view on the NCRMD defense is that these individuals receive much more education on the topic of mental illness than individuals without a psychology degree. However, it has also been demonstrated that completing a single course in the area of criminal justice or corrections may be enough to reduce negative attitudes as well,

suggesting that a little education can go a long way. Similarly, individuals with a more accurate understanding of either schizophrenia or common NCRMD sentences have a more positive view of the defense.

To decrease negative attitudes, providing formal education is one possibility. It may be a good starting point to require anybody who has a say in a NCRMD decision to complete a course in either mental illness or the specifics regarding the decision, including the dispositions, the prevalence rates, and the success rates. It would also be a good idea for anybody who would like to see change in the laws associated with the NCRMD defense to also receive some kind of formal education on the topic. This might be very important in terms of combatting Bill C-14. Perhaps if these individuals were more knowledgeable of the current standard, the Bill might never have emerged.

Formalized education programs may be helpful, but there is more that can be done within society on a daily basis. As with any case of stigma reduction, it is important to acknowledge and discredit stigmatizing statements when they are seen or heard. If inaccurate statements are continually challenged by more accurate knowledge, the hope is that the prevalence of stereotypes and negative, inaccurate beliefs about mental illness and the NCRMD defense will steadily decline.

Limitations and Future Research

A limitation of the present study was that it did not look at gender differences in perceptions toward the NCRMD defense. This was a factor that was of initial interest, although no hypotheses were made due to a lack of previous research on this factor. However, due to a very uneven gender distribution within the participants of the present study, it was decided that it would be unwise to make any comparisons between genders.

A second limitation of the present study was that age differences were not taken into consideration in regard to perceptions of the NCRMD defense. This was another factor of interest and, as with gender, no hypotheses were generated as a result of a lack of previous research. There was a very wide age range of participants. However, the distribution was very uneven, with the vast majority of participants being young adults and only a small percentage of participants being older. It was decided to refrain from making any comparisons in terms of age as there were not enough participants of different ages to separate them into appropriate age categories.

A third limitation, which is inextricably related to the first two, is that the study may not be generalizable to the public. It is likely that the results of the study can be generalized to young, adult women, but one must be weary to make any assumptions about other groups of people based on these results.

One area of future research stems directly from the present study's aforementioned limitations. Both the factors of gender and age should be investigated. If any groups of people who have particularly negative views of the NCRMD defense could be identified, targeting these groups would be much more feasible. On a similar note, spending valuable resources educating people who do not need this type of intervention and who already have an accurate, positive view of the defense would be counterproductive. Becoming more aware of which groups should be particularly targeted, and which groups do not specifically need to be targeted, could only be beneficial.

Another area of research that would be useful to explore would be examining the perceptions of offenders who commit crimes as a result of side effects of a prescribed

opiate. It was expected that the public would be harsh toward an individual who decided to take a powerful drug for recreational purposes and then committed a crime. However, it is interesting to see how negative the perceptions are toward an individual who committed a crime due to side effects of a drug that the individual was given by a doctor for a specific medical reason. It would be beneficial to gain a better understanding of the factors influencing these perceptions. Perhaps people are not aware of how powerful these side effects can be and therefore do not believe the drug has the ability to cause such powerful hallucinations. On the contrary, maybe people are aware of these possible side effects, but regard the act of knowingly taking a drug as a choice, and therefore expect someone to take responsibility for any consequences of this choice. Whatever the reasons behind this finding, it is worth further exploration.

Conclusion

The findings of the present study suggest that the view of the NCRMD defense might not be as negative as it once was. However, the emergence of Bill C-14 is testament to the fact that there are still many people who have negative attitudes toward people with mental illness and the treatment of mentally ill offenders. The potential impact that education can have on these attitudes should not be understated. Knowledge of both mental illness and information related to the NCRMD defense has been demonstrated to promote positive views on the treatment of mentally ill offenders. In order for Bill C-14 to be effectively challenged, allocating resources to educating the public may be a favorable option.

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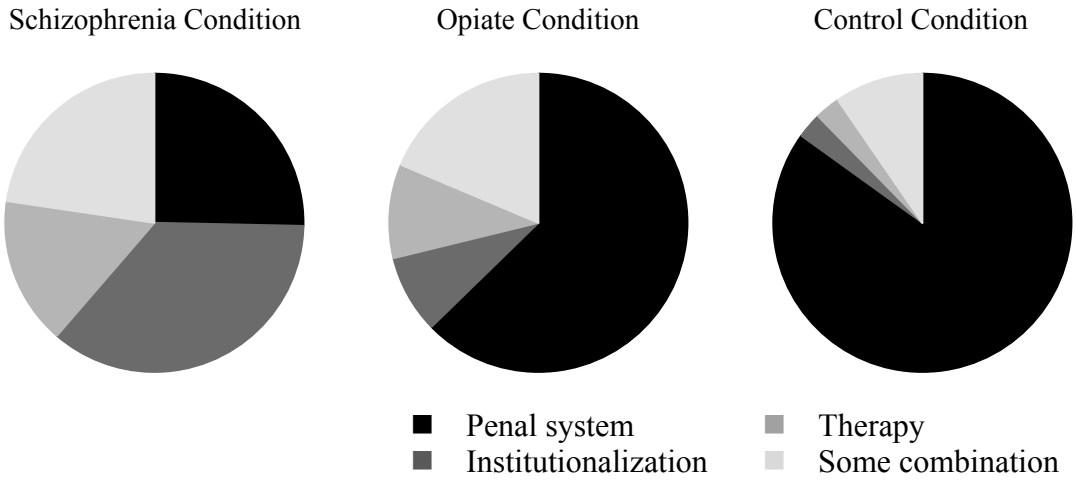

Figure 1. Distribution of punishment suggestions across different scenarios.

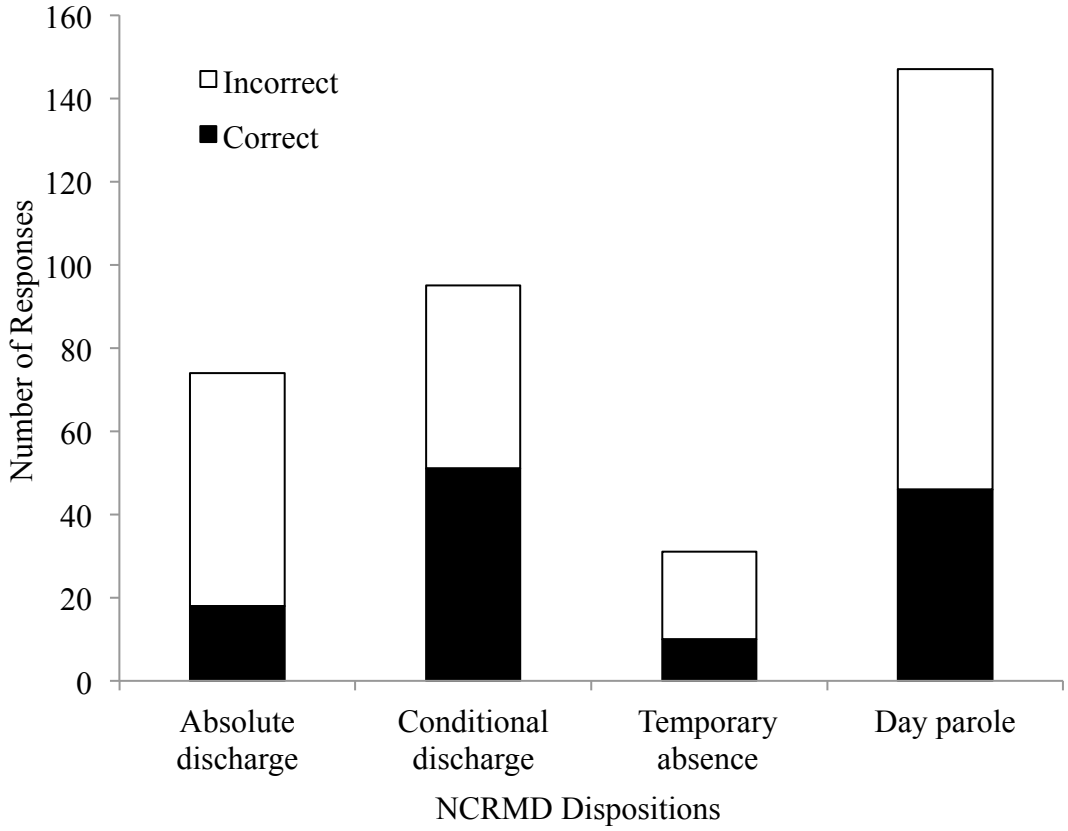

Figure 2. Frequency of correct and incorrect definitions provided for various common NCRMD dispositions.

Appendix A
Online Survey

My name is Jordan Power and I am currently completing a B.Sc. (Hons.) in psychology at Grenfell Campus, Memorial University of Newfoundland. As a requirement of this program, I am conducting the following research as part of an honours thesis.

In completing this survey you will be asked to read a short scenario and to answer a variety of questions. The survey is expected to take 10-15 minutes to complete. Your responses will be completely anonymous and confidential. You are asked not to put your name or any other identifying information on the survey and IP addresses will not be collected. Individual answers will be unidentifiable and only those who are directly involved with the study will be able to access the data. Participation is voluntary and if you wish to stop completing the survey at any point you can simply exit out of the page. Any unfinished surveys will not be included in the results. Also, if participation in the study has resulted in distress of any kind, you are encouraged to contact the Mental Health Crisis Line by calling (709) 777-3200 or 1-888-737-4668 (toll free). This provincial service is available 24 hours a day, 7 days a week. If there are any questions, comments or concerns, feel free to contact me at jppower@grenfell.mun.ca or my supervisor Dr. Kelly Warren at kwarren@grenfell.mun.ca. You can request a summary sheet of the results through one of the aforementioned email addresses after April 2015.

By proceeding to the next page, consent is implied.

The proposal for this research has been reviewed through an ethics review process in the psychology program at Grenfell Campus, Memorial University of Newfoundland and has been found to be in compliance with Memorial University's ethics policy. If you have ethical concerns about the research (such as the way you have been treated or your rights as a participant), you may contact the research supervisor, Dr. Kelly Warren.

In Canada, a *not criminally responsible on account of mental disorder* (NCRMD) defense can be used to remove the responsibility of an individual who did something that would otherwise be considered criminal. The goal of this study is to assess people's understanding of this defense. Please answer the following questions based on the scenario.

How responsible for the stabbing is the man who killed Sam?

Not at all responsible 1 2 3 4 5 6 7 Completely responsible

To what extent is a criminal punishment necessary?

Not at all necessary 1 2 3 4 5 6 7 Completely necessary

What would a suitable punishment be?

_____

What is the likelihood that the man who stabbed Sam will use the NCRMD defense?

Not at all likely 1 2 3 4 5 6 7 Extremely likely

How successful do you think the NCRMD defense would be in this case?

Not at all successful 1 2 3 4 5 6 7 Completely successful

How responsible is Sam for what happened?

Not at all responsible 1 2 3 4 5 6 7 Completely responsible

How familiar are you with the term "absolute discharge"?

Not at all familiar 1 2 3 4 5 6 7 Completely familiar

To the best of your knowledge, what is an absolute discharge? (Previous answer 4 or greater)

_____

How familiar are you with the term “conditional discharge”?

Not at all familiar 1 2 3 4 5 6 7 Completely familiar

To the best of your knowledge, what is a conditional discharge? (Previous answer 4 or greater)

_____

How familiar are you with the term “temporary absence”?

Not at all familiar 1 2 3 4 5 6 7 Completely familiar

To the best of your knowledge, what is a temporary absence? (Previous answer 4 or greater)

_____

How familiar are you with the term “day parole”?

Not at all familiar 1 2 3 4 5 6 7 Completely familiar

To the best of your knowledge, what is day parole? (Previous answer 4 or greater)

_____

To better understand the factors that impact attitudes towards the responsibility and treatment of offenders who have or do not have a mental disorder, I would like to briefly assess public knowledge of schizophrenia. Please select the number that, to the best of your knowledge, makes each statement accurate.

People with schizophrenia…

…have split/multiple personalities.

Never 1 2 3 4 5 6 7 Always

…hear voices.

Never 1 2 3 4 5 6 7 Always

…socially withdraw.

Never 1 2 3 4 5 6 7 Always

…are dangerous and violent.

Never 1 2 3 4 5 6 7 Always

…should be institutionalized.

Never 1 2 3 4 5 6 7 Always

…can be treated.

Never 1 2 3 4 5 6 7 Always

…can be cured.

Never 1 2 3 4 5 6 7 Always

ATTITUDE SURVEY

(Skeem, Louden, & Evans, 2004)

On this screen you will find statements that express commonly held opinions about the NCRMD defense. I would like to know how much you agree or disagree with each of these statements. Below each statement is a rating scale. You may interpret the seven points on this scale as follows:

1	2	3	4	5	6	7
STRONGLY DISAGREE	**DISAGREE**	**SLIGHTLY DISAGREE**	**NEUTRAL**	**SLIGHTLY AGREE**	**AGREE**	**STRONGLY AGREE**

After reading each statement, please select the number on the scale that comes closest to saying how much you agree or disagree with the statement.

---

1. I believe that people should be held responsible for their actions no matter what their mental condition.

Disagree 1 2 3 4 5 6 7 Agree

2. I believe that <u>all</u> human beings know what they are doing and have the power to control themselves.

Disagree 1 2 3 4 5 6 7 Agree

3. The NCRMD defense threatens public safety by telling criminals that they can get away with a crime if they come up with a good story about why they did it.

Disagree 1 2 3 4 5 6 7 Agree

4. I believe that mental illness can impair people's ability to make logical choices and control themselves.

Disagree 1 2 3 4 5 6 7 Agree

5. A defendant's degree of mental disorder is irrelevant: if the person commits the crime, then that person should do the time.

Disagree 1 2 3 4 5 6 7 Agree

6. The NCRMD defense returns disturbed, dangerous people to the streets.

Disagree 1 2 3 4 5 6 7 Agree

7. Mentally ill defendants who plead NCRMD have failed to exert enough willpower to behave properly like the rest of us. So, they should be punished for their crimes like everyone else.

Disagree 1 2 3 4 5 6 7 Agree

8. As a last resort, defense attorneys will encourage their clients to act strangely and lie through their teeth in order to appear mentally disordered.

Disagree 1 2 3 4 5 6 7 Agree

9. Killers without mental disorder can get away with their crimes by hiring high-priced lawyers and experts who misuse the NCRMD defense.

Disagree 1 2 3 4 5 6 7 Agree

10. The NCRMD defense is a loophole in the law that allows too many guilty people to escape punishment.

Disagree 1 2 3 4 5 6 7 Agree

11. We should punish people who commit criminal acts, regardless of their degree of mental disturbance.

Disagree 1 2 3 4 5 6 7 Agree

12. It is wrong to punish people who commit crimes while gripped by uncontrollable hallucinations or delusions.

Disagree 1 2 3 4 5 6 7 Agree

13. Most defendants who use the NCRMD defense are truly mentally ill, <u>not</u> fakers.

Disagree 1 2 3 4 5 6 7 Agree

14. Some people with severe mental illness are out of touch with reality and do not understand that their acts are wrong. These people cannot be blamed and do not deserve to be punished.

Disagree 1 2 3 4 5 6 7 Agree

15. Many of the criminals that psychiatrists see fit to return to the streets go on to kill again.

Disagree 1 2 3 4 5 6 7 Agree

16. With slick attorneys and a sad story, any criminal can use the NCRMD defense to finagle his or her way to freedom.

Disagree 1 2 3 4 5 6 7 Agree

17. It is wrong to punish someone for an act they commit because of <u>any</u> uncontrollable illness, whether it be epilepsy or mental illness.

Disagree 1 2 3 4 5 6 7 Agree

18. I believe that we should punish a person for a criminal act <u>only</u> if that person understood the act as evil and then freely chose to do it.

Disagree 1 2 3 4 5 6 7 Agree

19. For the right price, psychiatrists will probably manufacture a “mental illness” for any criminal to convince the jury that he or she is mentally disordered.

Disagree 1 2 3 4 5 6 7 Agree

The Canadian government is currently proposing changes to the way mentally ill offenders are treated. I would like to know how you feel about the treatment of mentally ill offenders.

Mentally ill offenders should be handled by mental professionals.

Strongly disagree 1 2 3 4 5 6 7 Strongly agree

Mentally ill offenders should be handled by correctional employees.

Strongly disagree 1 2 3 4 5 6 7 Strongly agree

Once released back into the community, mentally ill offenders are not properly monitored.

Strongly disagree 1 2 3 4 5 6 7 Strongly agree

Mentally ill offenders should be imprisoned indefinitely.

Strongly disagree 1 2 3 4 5 6 7 Strongly agree

Is there anything else you would like to add?

_____

Demographics

Age: _____

Gender: ☐Male ☐Female ☐Other _____

Do you have experience with mental illness? (Check all that apply)
☐ Personal experience
☐ Work experience
☐ Completed or currently completing psychology degree
☐ Other (Please specify) _____

Do you have any experience with criminal justice or corrections? (Check all that apply)
☐ Completed course work in criminal justice or corrections
☐ Work/have worked in criminal justice or corrections
☐ Completed course work in psychology, sociology, criminology or some other

discipline that discussed criminal justice or corrections

☐ Other (Please specify) _____

Thank you for participating in my study.

The goal of this study is to examine public knowledge about the current laws governing mentally ill offenders, as well as the feelings towards how mentally ill offenders are treated. I would also like to compare attitudes towards offenders who have versus do not have mental disorders and examine potential reasons for differences in these attitudes.

If participation in the study has resulted in distress of any kind, you are encouraged to contact the Mental Health Crisis Line by calling (709) 777-3200 or 1-888-737-4668 (toll free). This provincial service is available 24 hours a day, 7 days a week. If there are any questions, comments or concerns, feel free to contact me at jppower@grenfell.mun.ca or my supervisor Dr. Kelly Warren at kwarren@grenfell.mun.ca. You can request a summary sheet of the results through one of the aforementioned email addresses after April 2015.

The proposal for this research has been reviewed through an ethics review process in the psychology program at Grenfell Campus, Memorial University of Newfoundland and has been found to be in compliance with Memorial University's ethics policy. If you have ethical concerns about the research (such as the way you have been treated or your rights as a participant), you may contact the research supervisor, Dr. Kelly Warren.

Appendix B
Scenarios

Schizophrenia Condition

It is midday and Sam is waiting for the bus at a local bus stop. As Sam is waiting, he notices a man walking up the opposite side of the street towards him. The man crosses the road and approaches Sam. As he gets closer, Sam notices that the man is mumbling to himself and looks distressed. Sam proceeds to ask the man if he needs any assistance, but the man abruptly hauls out a knife and stabs Sam in the stomach. He succumbs to his wounds at the scene. The man who stabbed Sam is found in a nearby neighborhood two hours later and is immediately apprehended by police. He had previously been diagnosed with schizophrenia and had occasionally reported suffering from hallucinations.

Opiate Condition

It is midday and Sam is waiting for the bus at a local bus stop. As Sam is waiting, he notices a man walking up the opposite side of the street towards him. The man crosses the road and approaches Sam. As he gets closer, Sam notices that the man is mumbling to himself and looks distressed. Sam proceeds to ask the man if he needs any assistance, but the man abruptly hauls out a knife and stabs Sam in the stomach. He succumbs to his wounds at the scene. The man who stabbed Sam is found in a nearby neighborhood two hours later and is immediately apprehended by police. He had recently been prescribed an opiate for chronic back pain, a possible side effect of which was hallucinations.

Control Condition

It is midday and Sam is waiting for the bus at a local bus stop. As Sam is waiting, he notices a man walking up the opposite side of the street towards him. The man crosses the road and approaches Sam. As he gets closer, Sam notices that the man is walking very quickly and looks distressed. Sam proceeds to ask the man if he needs any assistance, but the man abruptly hauls out a knife and stabs Sam in the stomach. He succumbs to his wounds at the scene. The man who stabbed Sam is found in a nearby neighborhood two hours later and is immediately apprehended by police. He had no history of mental illness, and a toxicology report showed there were no drugs present in his system.

Appendix C
Email Exchange

From: Jordan Power <jordanp977@hotmail.com>
Subject: Insanity Defense Attitude Scale
Date: October 1, 2014 at 11:24:15 AM PDT
To: "jenskeem@berkeley.edu" <jenskeem@berkeley.edu>

Dear Dr. Skeem,

I am currently completing an honours thesis for my bachelors degree in psychology at Grenfell Campus, Memorial University of Newfoundland, Canada.

I am interested in perceptions of mental illness, but more specifically perceptions of mentally ill offenders. Recently, the Canadian government has proposed changes to current practices used with mentally ill offenders that include a focus on letting the courts and not necessarily mental health professionals make decisions regarding the sentencing and treatment of such offenders. I am interested in public perceptions of the proposed changes and how perceptions relate to both knowledge regarding mentally ill offenders and stigmas toward those with a mental illness. I plan on looking at knowledge, attitudes and stigma towards individuals with mental illness in general, but I would also like to look at what people know and how they feel about the Not Criminally Responsible on Account of Mental Disorder defense.

Through my research I came across a handful of studies that had used your Insanity Defense Attitude Scale. I was wondering if you would grant me permission to use this scale as well, with a few minor adjustments to more accurately represent Canadian Law. Essentially, I would like to change the wording specific to the insanity defense to NCRMD as it is known in Canada. I believe the addition of the scale in my survey would enable me to make the most of my research. I look forward to hearing from you.

Respectfully,
Jordan P. Power

Begin forwarded message:

From: Jennifer Skeem <jenskeem@berkeley.edu>
Subject: Fwd: Insanity Defense Attitude Scale
Date: October 5, 2014 9:59:29 AM MDT
To: Jennifer Eno Louden <jlenolouden@utep.edu>

Hi Jordan-

I received your email from Jen Skeem, who asked me to assist you. You are welcome to use the scale so long as you cite appropriately. I've attached the scale and scoring instructions. If you do make changes to the scale, please be clear in any reports/publications about the specific changes that were made. Please let me know if you have any questions.

Best,
Jennifer

--
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