



## The Criminalization of People With Mental Illness

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### Introduction

Mental illness, no matter how defined, has been with us for at least as long as recorded history. Over the centuries, there have been trends in the way mental illness is viewed and treated by society. No matter the language used, society has attached stigma and applied discrimination, with differing intensity and effect. There have, however, been people who have embodied altruism and care. In 1841, Dorothea Dix was sufficiently moved by the plight of prisoners with mental illness held under inhumane conditions to lobby for psychiatric hospitals. Within forty years of her efforts, U.S. jails went from containing large numbers of poorly treated prisoners with mental illness to the point where they constituted only 0.7 per cent of inmates.<sup>1</sup> Further and ongoing efforts to provide humane and enlightened treatment for people with mental illness resulted in the construction of a large number of state and provincial psychiatric hospitals across North America. These hospitals were often on large grounds, with a pastoral setting, often with working farms, all with the intent of creating asylum for those troubled by mental illness.

Similarly at about the same time in Canada, a Royal Commission in New Brunswick was struck in 1836 to plan the first asylum. The Commission indicated that people with mental illness should have a premises that would

afford diversion and interest, excite conversation, and give constant proofs that they are in a world of hope, and among beings who are engaged in the every day affairs of life. The grounds should be ornamented, and everything about the establishment should give evidence of care and comfort.<sup>2</sup>

The moral treatment movement, which had begun with Philippe Pinel and later embodied by William Tuke, the York Asylum and the Quakers, gathered momentum and saw an increasing number of psychiatric hospitals built all over North America. As time went on, those asylums became overcrowded and institutional. Rather than places of sanctuary and treatment, some became places to warehouse people with mental illness. Nonetheless, because of various selfless and public-minded people, religious organizations and associations, caring and compassion coexisted with overcrowding and abuse.<sup>3</sup>

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Coinciding with the discovery and use of psychotropic medications, in the 1950s and 1960s, patients began to be released from psychiatric hospitals, with the intention of treating them in the community. That wave, which commenced in the middle of the last century, continued to gather force to the point where psychiatric hospitals rapidly emptied and, in some cases, closed. However, there were also funding reasons that propelled the state hospitals to discharge patients into the community, where other government agencies would cover the cost of housing and support.

Deinstitutionalization of people with mental illness was initially seen as a liberal and enlightened movement. The idea that people with mental illness would be able to live happily in the community, with an array of services and supports, drove and justified this movement. In addition, psychotropic medications, despite their not infrequent side effects, did make a significant difference in ameliorating and relieving symptoms of psychosis, and later those of mood disorders, allowing previously nonfunctional people an opportunity to enter the community and function outside hospitals.

Unfortunately, and for various reasons, the intended comprehensive community support systems that were meant to be in place either did not materialize, materialized and then evaporated, or were just insufficient to manage the flood of patients with mental illness now living in the community, and later on the streets.<sup>4</sup> Unfortunately, too, along with the reduction in psychiatric beds in Canada and the United States (and much of the industrialized world), an increase began in the number of people with mental illness within the also enlarging criminal justice system.<sup>5</sup>

The information about the increasing numbers of people with mental illness in the criminal justice system was slow to come to light, manifesting in the 1970s. The increase of people with mental illness within the criminal justice system appeared to correspond with the reduction in psychiatric beds,<sup>6</sup> and the notion that people with mental illness were becoming criminalized became better publicized.<sup>7</sup> Along with the increasing number of people with mental illness in jails and prisons came the myriad of associated problems, such as victimization of incarcerated people with mental illness and difficulty getting timely psychiatric care.

This paper addresses the trend of deinstitutionalization, transinstitutionalization and the consequent criminalization of people with mental illness.

## Background

There are many indicators of the increasing criminalization of people with mental illness, especially evident in data coming out of the United States. Canada has, to a large extent, followed suit, with the potential for further negative consequences in years to come. It was

probably a decade or two after the psychiatric hospitals commenced closing, and as deinstitutionalization gathered steam, that the increased numbers of people with mental illness began to be noticed in jails and prisons. Thus it was likely in 1970 that the first reports of increasing numbers of people with mental illness in jails and prisons started to emerge. An example of this trend comes from a report that after Agnews State Hospital in Santa Clara County closed in the early 1970s, the local county jail's population of people with mental illness increased by 300 per cent.<sup>8</sup> However, not only were the number of people with mental illness increasing in the correctional system, but also the number of people incarcerated in general rose.

In 1955, there were 559,000 state hospital beds for a population of 164 million people. By 1994, there were only 72,000 state hospital beds for a population of 250 million people. The beds per 100,000 people had dropped dramatically from 339 to 29. Contemporaneously, the number of people in jails and prisons also rose significantly.<sup>9</sup> The other side of the same phenomenon was the increasing number of prisoners associated with the reduction in psychiatric hospitals. Between 1980 and 1995, the total number of people incarcerated in the United States rose from 501,836 to 1,587,791, a 216 per cent increase—the population at that time increased by only 16 per cent.<sup>16</sup>

There have been several studies looking at who constituted the increasing correctional population.<sup>10</sup> The well-known Epidemiologic Catchment Area Survey showed a prevalence rate of schizophrenia and the major affective disorders at three to six times greater in the prison population than in the community at large. Interestingly, bipolar disorder was six times greater among prisoners than in the community.<sup>11</sup> There have also been various studies looking at the prevalence of mental illness within the United States criminal justice system. Steadman et al<sup>12</sup> found that eight per cent of New York state prisoners had major mental illnesses. In 1999, the U.S. Department of Justice indicated that 16 per cent of all inmates in state and federal jails and prisons had schizophrenia, bipolar disorder, major depression or other severe mental illnesses. This study estimated that, on any given day, there were 283,000 people with severe mental illness incarcerated in federal and state jails and prisons. Contrasting that, at the same time there were only 70,000 people with severe mental illness in public psychiatric hospitals, and 30 per cent of those were forensic patients.<sup>13</sup>

Other data would suggest that, in June 2004, there were 2.1 million inmates in the United States in prisons and jails. Estimates for people with severe mental illness ranged from 10 per cent to 19 per cent in jails, 18 per cent to 27 per cent in state prisons and 16 per cent to 21 per cent in federal prisons. Using the lowest

estimates, there were 71,399 people with severe mental illness in jails; 223,386 in state prisons; and 27,099 in federal prisons, for a grand total of 321,884.<sup>14</sup>

The estimate in the National Commission on Correctional Healthcare Report to Congress in 2002 suggested 15 per cent to 24 per cent of U.S. inmates have severe mental illnesses. Another report states that one-half of the inmates, with an estimated population of over one million, each have one mental health condition.<sup>15</sup> An oft-quoted statistic is that the largest mental institution in the United States is actually the Los Angeles County Jail. In fact, the Twin Towers Correctional Facility, which treats people with mental illness in Los Angeles County Jail, has a daily census of 5,000. In 2001, research showed that in the L.A. County Jail itself, 28 per cent of men and 31 per cent of women had symptoms of a major mental illness.

Canada has also been affected by similar trends.<sup>16</sup> We know that, in 1959, there were 65,000 beds in mental hospitals across Canada, and by 1976 the bed count had dropped to 15,000 in provincial hospitals and 6,000 in general psychiatric units. In 2002, the Health Systems Residential Research Unit at the Centre for Addiction and Mental Health looked at in- and outpatients in Toronto and Peel. They also sampled Toronto court-supported clients and found that 47 per cent needed at least weekly follow-up but only two per cent received it. In Canada, as the psychiatric hospital beds decreased, the jails and prisons increased capacity. For example, in British Columbia, in 2011, there were 1,692 cells housing 2,655 inmates.

Canada has other issues with its correctional systems. For instance, we do know that one-third of federal female inmates and one-fifth of male federal inmates are of Aboriginal descent—a significant overrepresentation of this population group. In addition, it is expensive to manage prisoners. It costs over \$100,000 per year to house and support a male federal inmate and over \$180,000 per year to manage and support a female inmate. Compare that to one-eighth of that cost for parolees in the community.<sup>17</sup>

New legislation in Canada is likely to result in increased number of inmates—in all probability with significant numbers of people with mental illness in that group. Various sentencing changes, including the Canadian Truth in Sentencing Act in February 2010, will lead to longer sentences and fewer parolees. There appears to be a greater emphasis on punishment, with curtailed parole and limited visitation. Incarcerated people with mental illness are likely to be disproportionately negatively affected by these changes.

Canada has about 14,000 inmates in the federal correctional system and 87,000 on parole in the community. Among the 500 female inmates, 30 per cent have been hospitalized for some psychiatric

reason—compared with 14.5 per cent of men—and 25 per cent have psychiatric diagnoses. Among those inmates housed in maximum-security settings, up to one-third are in segregation at any one time, and many people with mental illness reside there. The daily segregation count in the federal correctional system is 900, with an average of 95 days in segregation; 177 of that 900 have segregation periods of over 110 days.<sup>17</sup>

Correctional systems are not benign. Suicide rates for incarcerated people are elevated at 84 per 100,000 in the correctional system, compared with 11.3 in the community; homicide, for those incarcerated, is 28 per 100,000, compared with 1.8 in the community.<sup>17</sup>

## Discussion

It has become increasingly apparent that people with mental illness are represented in disproportionate numbers within the jails and prisons of our country. In this regard, numerous factors have been described as being contributory. These include deinstitutionalization (or, as others would describe it, dehospitalization). There have been numerous theories during the years suggesting that fewer hospital beds will result in more people with mental illness being arrested and incarcerated. One of the better known theories is that of Penrose, who, in 1939, suggested that a relatively stable number of people are confined in any industrial society. He looked at prison and mental hospital census data from 18 European countries and found an inverse relation between prison and mental hospital populations. His theory was that if either of these forms of restriction were reduced, the other would increase. Thus as hospitals beds increase, prison beds will decrease; as hospital beds decrease, prison beds increase, and people with mental illness will move from one institution to another.<sup>18</sup> His theory appears to be holding true in Canada and the United States.

The promise of deinstitutionalization included a shifting of resources from the hospital sector to the community. Language, theory and enthusiasm for this again heralded an enlightened and progressive approach to mental illness. Psychiatrists, especially those working in institutions, were among the few voices suggesting some caution; however, they were muted as the initiative gathered steam. Various levels of government saw this not only as progressive health care but also for the associated cost savings and union busting as desirable consequences of this initiative. The voices of psychiatrists calling for caution were initially muted and then maligned. As this movement progressed, patients became clients and consumer-survivors (of the psychiatric treatment, not the illness), and the hospital sector in psychiatry went on the defensive. For various economic and social reasons, the money from the hospital sector either did not make its way to the

community or, if it did, did so in small amounts and for brief periods of time. Over the years it became apparent that the services for people with mental illness in the community were woefully inadequate. The asylum now became a small, poorly policed and poorly resourced group, or boarding homes in the community where the profit motive often reduced services. Patients were, in essence, out on the street—and now running afoul of the criminal justice system with increasing frequency.

Coinciding with the closure of hospital beds without adequate community resources was a honing of civil commitment criteria.<sup>19</sup> It became much more difficult for physicians to detain people with mental illness in hospitals when unwell, and also difficult to maintain them in hospitals. An increasingly sophisticated legal bar, and a series of laws designed to safeguard the rights of people with mental illness, had the unintended consequence of shorter lengths of stay and brief periods of treatment, often terminating when civil commitment risk issues subsided but before independent function and true insight returned. This resulted in the so-called revolving-door phenomenon, well known to families of people with serious mental illness.

Additionally, as hospitals became increasingly managed, and as length of stay became an important metric for reducing costs, pressure on the hospitals, and on the physicians and staff, to reduce the length of stay of patients contributed to briefer hospitalization in public general hospitals. In addition, some provincial fee codes discouraged longer hospital stays and signaled to new medical graduates that psychiatry and the treatment of people with mental illness was valued less than other medical or surgical specialties.

On a more positive note, Section XX.1 of the Criminal Code of Canada underpins society's view that people with mental illness who come into conflict with the criminal justice system need to be treated in a humane fashion.<sup>20</sup> The Criminal Code allows for those who, when mentally ill, commit an offence such that they are found not criminally responsible (NCR) by virtue of that mental disorder if that disorder caused them not to appreciate the nature and quality of their act or omission, or to know that it was wrong from a legal or moral perspective. The Criminal Code was changed in 1992. 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*,<sup>21</sup> the Supreme Court of Canada held that this practice was unconstitutional.

The range of offences for which an NCR defence may be raised was expanded. However, this change coincided with, once again, decreasing hospital beds and few community resources for treating people with mental illness. The change in the Criminal Code now allowed any accused or Crown to raise the issue of NCR.

From a lay perspective, it continued to seem that the behaviour of people with mental illness was beyond their control, suggesting that it is actually mental illness driving criminal behaviour, as opposed to the individual or choice. One of the unintended consequences is reflected in *Mad in America*, in which Robert Whittaker wrote, “in the pecking order of the social discards, asylum patients fell below criminals.”<sup>22, p 69</sup> Various forces led to family members, who were concerned about the lack of treatment for their beloved, and well-meaning health care professionals, to engineer criminal responsibility assessments for revolving-door patients and patients with minor offences. All of a sudden, the forensic system began to fill with patients who previously would have been in the tertiary psychiatric units in psychiatric hospitals. People with mental illness—subject to limited bed availability, reduced length of stay and woefully inadequate civil legislation to keep them in hospital long enough to treat the illness completely—were being diverted into the forensic mental health system. Projections from the turn of the last century suggested that, within a few years, the forensic system would ultimately encompass all of the patients previously occupying tertiary psychiatric beds. It was only with the Supreme Court of Canada case, *Winko v. British Columbia* (Forensic Psychiatric Institute), in 1999, that the tide turned.<sup>23</sup> In the *Winko* case, the onus for proving “significant risk” now fell to the hospital, rather than the patient, to prove the patient was not a risk. There was a subsequent increase in absolute discharges, and the number of Review Board cases reached a plateau for a while.

It was during this period that the closure of facilities dealing with the intellectually disabled population has meant that this population now occupies between 10 per cent and 15 per cent of the forensic beds in Ontario. Inadequate facilities for the elderly with mental illness drive similar outcomes. Both of these groups, with their cognitive impairment, are, when charged, found unfit to stand trial. Often there is no hope of becoming fit to stand trial, with the result that these groups become permanent forensic patients, which is surely not an intended function of the forensic system and Section XX.1 of the Criminal Code.

People with mental illness, with limited access to psychiatric hospital beds, running into difficulty with the criminal justice system and being incarcerated at increasing rates, were diverted into the forensic system where they at least could get psychiatric care, albeit by acquiring a criminal justice history. Whatever rights to treatment psychiatric patients had, many believed that the only way they could receive treatment was by charging them and getting them placed in the forensic system. The forensic so-called platinum card for psychiatric care came at a cost of criminalizing the patient.

Psychiatrists—poorly resourced and under pressure to reduce length of stay—sometimes saw the prison and jail system as an extension of a hospital environment. Few psychiatrists have visited Canada’s correctional facilities, and few are aware of the challenges facing inmates or staff. Very few people appreciate that it is extremely hard to treat a patient with mental illness in a correctional facility, and, in the vast majority of settings, people with mental illness cannot be treated against their will, or encouraged to take medications, for psychiatrists’ fear of being seen as coercive. In addition, jails and prisons can be brutal places where people with mental illness—often unstable and exhibiting poor judgment—are victimized and terrorized. Correctional staff, who, for the most part, are not trained to manage people with mental illness, struggle to deal with people who, even when in a hospital setting, would be challenging people to treat.

Fortunately, there is an increasing recognition that people with mental illness in Canada have been unfairly criminalized, and moves are afoot to address this crisis. Money and resources have been applied to assist police in diverting people with mental illnesses before they get charged.<sup>24</sup> Police have an opportunity of taking a person who is committing or commits a minor offence to a hospital rather than arrest them. Better education and resources have meant that the appropriate decision gets made more readily. Court support workers have worked with lawyers and Crown attorneys to create diversion programs within courthouses in situations where charges may be stayed if mental illness is a factor, the charges are not serious and the treatment is envisaged. In addition, there has been a proliferation of mental health courts.<sup>25</sup> Although these courts are not without their critics, they are based on the principle of therapeutic jurisprudence: the law should be used whenever possible to promote the mental and physical well-being of the people it affects.

Resources have been put in place to address homelessness as the revolving door now revolves between the streets and the criminal justice system rather than the hospital and the community. Police–nurse teams have been funded,<sup>9</sup> community assertive treatment teams have increased their reach and various intersectoral committees have been struck to address the plight of people with mental illness as they move from the street to the jails and back to the street.

Unfortunately, all of these may be seen as so-called Band-Aid solutions unless there are other resources in place. There remains a shortage of hospital beds, where often the imperative appears to be to keep people out of hospitals rather than use up scarce resources, especially for a population that is politically silent. Bed management systems are poorly modelled and do not accommodate the surges in bed requirements for people

with mental illness. As Richard Lamb has written, “Access to hospital care should be in place for those in need for as long as it is needed.”<sup>26, p.9</sup> Unfortunately, bed pressures and costs run counter to this assertion.

Societies are often judged by how their disadvantaged members are treated. People with serious mental illness within the criminal justice system clearly fall within the disadvantaged group, with the double stigma of their mental illness and a criminal justice label. Stigmatized and discriminated against, this is a population that begs for social justice and our urgent attention.

In its report, *Outpatient Services for the Mentally Ill Involved in the Criminal Justice System*, the American Psychiatric Association’s Task Force on Outpatient Forensic Services outlined four recommendations specific to psychiatry. They indicated that to restore the psychiatric system to a position of primacy in responding to problematic behaviour, psychiatrists must embrace the mission of serving patients in the criminal justice system. This involves commitment to the issues at hand. In addition, as forensic psychiatry has made few inroads into outpatient psychiatry, forensic psychiatric leadership in the outpatient sector is necessary.<sup>27</sup>

Although focusing on a particular population, the Task Force has recommendations with wider applicability and has indicated that public sector psychiatrists must acquire numerous skills to take on the care and management of offenders with mental illness. These include risk assessment and management, therapeutic use of coercive interventions, management of antisocial personality disorder and comorbid substance abuse, and sophistication in spanning systems.

Research also needs to be focused on services related to offenders with mental illness.

## Recommendations

The promise of deinstitutionalization has not been realized. Hospital bed closures have been too rapid and too extensive. Community resources remain underfunded and limited. Fragmentation in the health care system has meant that no one has taken responsibility for the care of one of the most disadvantaged and marginalized populations. Many people suffering from serious mental illnesses end up incarcerated, owing, in part, to lack of appropriate resources to treat them in the community, with correctional facilities becoming the de facto psychiatric institutions. Some people with mental illness receive their treatment only after being found NCR or unfit to stand trial. Access to care for many only occurs after they have been criminalized.

The Canadian Psychiatric Association (CPA) makes the following recommendations:

- Health, correctional services and psychiatric leaders come together to improve psychiatric resources for people with mental illness currently in detention centres and prisons.
- Psychiatry, and specifically forensic psychiatry, turn its attention to working with correctional psychiatrists to enhance the skills of those psychiatrists working in correctional settings. Attention should be given to recruitment, retention and training of correctional psychiatrists in Canada. We recommend that the Canadian Academy of Psychiatry and the Law and the CPA lead this initiative.
- The Canadian government strike a commission to review the effects of deinstitutionalization, specifically holding provincial governments accountable for appropriate psychiatric resources in the hospitals and the community.
- As psychiatric resources move to public general hospitals and to the community, close accounting needs to ensure funds are not diverted away from services for people with serious mental illness and directed to other patient populations.
- Governments reconsider separate funding streams for people with serious mental illness to ensure that there are sufficient psychiatric beds and resources available for people with mental illness for as long as they need them.
- Psychiatry residency programs across the country provide training and experience in dealing with offenders with mental illness, including exposure to Canada's detention centres and prisons.
- Research gets conducted into the predictors of people with serious mental illness becoming involved in the criminal justice system and the mechanisms to prevent criminal justice involvement, including how to manage the effectiveness of these mechanisms.
- Resources and services are put in place to provide appropriate and sufficient nonforensic, noncorrectional mental health treatment to prevent the criminalization of people with serious mental illness.
- Government reviews the impact of new crime legislation on people with mental illness so that they are not unfairly affected.
- The Mental Health Commission of Canada and Government create a mechanism to study and monitor the interplay among prisons, hospitals and the community.

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