Criminalizing Persons with Severe Mental Illness in Canada

The Legacy of Deinstitutionalization on Individuals with Severe Mental Illness

Capstone Project

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Abstract

The deinstitutionalization movement of the 1960s remains the most detrimental strategic shift in the psychiatric healthcare field to date. The changing philosophical landscape on best practices for members of society with severe mental illness (SMI) has catalyzed socio-economic problems for this already vulnerable people group. These issues include increased rates of substance abuse, homelessness, and criminalization amongst people with SMI. Early literature on the effects of deinstitutionalization overvalued the humanness of the system rather than systematically evaluating the benefits. The literature of the past 25 years has adopted a more critical view of the decentralized system. This critical appraisal amalgamated and evaluated the current data to determine whether the deinstitutionalization of people with SMI is truly beneficial for the patient. This research is intended to inform Canadian policymakers regarding the future of healthcare for people with SMI. The results of this research are important as they demonstrate the financial toll of deinstitutionalization; the yearly cost of the Canadian mental health system is purportedly CAD 50 billion (Mental Health Commission of Canada, 2013). Modern research indicates that deinstitutionalization as a mental health strategy can be effective but, due to the provincial inconsistency in community support, a lapse in care for comorbid patients and poor trans-institutional psychiatric care, it has contributed to the criminalization of people with SMI.

Keywords: Deinstitutionalization, institutionalization, substance abuse, homelessness, severe mental illness, and chronic mental illness

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Background

Since the advent of the deinstitutionalization movement in the 1960s, the rate of individuals with mental illness represented in the criminal justice system (CJS) has exponentially increased (Boyd & Kerr, 2015). Deinstitutionalization is described as, moving people with severe mental illness out of state-sponsored institutions and into the community. Deinstitutionalization was originally seen as a solution to the overburdened psychiatric institutions of the 1960s; made possible by the advent of antipsychotic medications in 1954 (Kliewar et. Al, 2009). Though originally viewed with optimistic fervour, the movement has received criticism in the last 25 years. Some researchers even analogized deinstitutionalization as "A psychiatric Titanic" (alluding to its failures) (Torrey, 1997, para. 10). The negative effects of deinstitutionalization have long been studied. Leils Sinnen noted in her master's thesis that many patients with chronic mental illness who have been deinstitutionalized consistently experience the negative effects of revolving door syndrome, stigma, and homelessness (1987). For context, Sinnen defined the revolving door syndrome as the tendency for individuals with mental illness to heal temporarily, only to relapse later. Based on this research, one can conclude that increasing the homeless population, which in Canada is directly tied to deinstitutionalization, only creates more social and economic problems (Read, 2009).

The deinstitutionalization and subsequent criminalization of people with mental illness in Canada is a serious problem because it infringes on individual rights, contributes to an overburdened CJS, and erodes the fragile trust between the police and the public. The programs now implemented to train officers to safely respond to calls involving individuals with a mental illness are one of many new costs not incurred under the old system. For example, the Saskatoon

Police Service increased its mental-health training budget by 265% between 1992 and 2012 (Public Safety Canada, 2013).

The philosophical worldview guiding the research conducted in this critical appraisal is the postpositivist perspective. Post positivism argues that there is an assumed relationship between causes and outcomes but, in contrast to positivism, it focuses on the holistic understanding of phenomena rather than causality (Fox, 2008). Previous studies from the 1960s to 1990s tend to support the deinstitutionalization models for people who are chronically mentally ill. More recently, however, there has been a surge in the literature examining the tripartite connection between mental illness, homelessness, and criminality. This critical appraisal will challenge the previously held belief that deinstitutionalization is objectively better for those with SMI.

Research Question

The field of research surrounding the criminalization of people with severe mental illness is vast but when one attempts to isolate the symptoms that derive directly from deinstitutionalization, the body of research quickly shrinks. The research that does exist is particularly polarized. Original research viewed deinstitutionalization as a miracle cure that made economic sense and simultaneously restored dignity to a marginalized population. Presently, the research is far more critical as, the post-modernist worldview has generally replaced the modernist approaches of the late 19th and early 20th centuries (Hasa, 2016). Therefore, this capstone project attempts to answer the research question: during the past 25 years, has the deinstitutionalization movement inadvertently criminalized mental illness in the Canadian criminal justice system?

To better understand the repercussions deinstitutionalization has had on people with severe mental illness (SMI) in Canada, the author is conducting a critical appraisal. This type of research is best suited when there is little peer-reviewed consensus in the field of study. Critical appraisals aim to find a definitive answer to a specific question which has the dual effects of both spurring further research by isolating gaps in knowledge and helping politicians make informed decisions on the future direction of society. Additional sub-questions have been introduced that commonly occur as comorbid issues to SMI.

The sub-questions are:

- To what degree does drug addiction contribute to the criminalization of people with mental illness?
- To what degree does homelessness contribute to the criminalization of people with mental illness?

The research conducted in this annotated bibliography focuses on articles released in the past 25 years. The timeline is relatively recent, as will be discussed later, along with the inclusion and exclusion criteria in the literature search and review plan. The independent variable was the implementation of deinstitutionalization in the Canadian healthcare system primarily, but not limited to, the 1960s. The dependent variable was the change in the degree to which people with SMI were and are criminalized in Canada. Some examples of ways this has been measured include the rates of individuals entering the CJS with a SMI, comparing the inflating budgets of the CJS to the health care system and grading the level of care distributed to people with SMI within the correctional system. The hypothesis is that the deinstitutionalization movement has significantly contributed to the criminalization of people with SMI.

Methodology

This critical appraisal examined secondary data research collected from 15 different studies that were either quasi-experimental, experimental, or participant observation covering both qualitative and quantitative studies. The secondary research was gathered and weighted to determine if the majority of research found a positive or negative link between deinstitutionalization and criminalization. It will either unequivocally support the hypothesis and prove that deinstitutionalization is an inadequate approach to psychiatric healthcare, or it will refute the hypothesis and be used to safeguard deinstitutionalization. As the research included will be strictly secondary data, there are no specific research techniques used in this critical appraisal.

To source research for this annotated bibliography, the author relied on two separate databases: the Justice Institute of British Columbia (JIBC) Library Database and Google Scholar. These databases are vast and offer a wide variety of peer-reviewed articles. The literature keywords used were: "deinstitutionalization or downsizing"; "mentally-ill or criminally insane"; "criminalization"; "drugs"; "homelessness" and lastly "Canada". The search terms derive from the research question and the sub-questions.

Evidently, as the research question and sub-questions center around endemic problems such as poverty, mental illness, drug use and criminality, the initial search results were far too expansive to be of any use. To further refine the literature search, the author conjoined various search terms to look at the specific comorbidity of people with mental illness and criminalization.

Boolean search operators such as "and" and "or" were utilized to increase the width of the search. To reduce the overload of unrelated data, the following inclusion criteria were established and applied to the search terms. The first criterion was: peer-reviewed articles. This

is to ensure that all literature is accurate and above reproach. The second criterion was: articles that range from 1997 to 2022 (the past 25 years). The researcher will only accept articles dated after 1997 as research that was conducted between 1960 and 1997 was viewed through an overly idealistic lens due to the rapid gain in popularity of deinstitutionalization (Spagnolo, 2014). The third criterion was: English results only so that the author can understand and synthesize the findings.

The researcher then developed additional exclusion criteria. The critical appraisal research was limited to research conducted on adults, research conducted inside of Canada, fully accessible articles, articles that are available online and articles focused on the experience of individuals who have a SMI. These were applied manually by examining the literature. The author excluded any research conducted on minors which, in Canada, is any person under the age of 19 (in the majority of provinces). This was established because the circumstances for a child with a mental illness and an adult with a mental illness are vastly different due to variability in familial support structures.

The author limited the scope to Canadian research to limit the impact of social, economic, and political influences that other countries might have on the research as countries have experienced the impacts of deinstitutionalization differently. This will limit the usefulness of the findings of this critical appraisal to the Canadian context and it will help to legitimize the results by excluding as many confounding variables as possible. Using resources that are strictly available online ensures that the articles can be sourced for further research. Lastly, this critical appraisal is focused solely on the people who suffer from a SMI and therefore will exclude any other findings related to less intrusive mental illnesses such as anxiety disorders.

The established exclusion criteria are as follows: non-peer-reviewed articles, articles published before 1997, non-English articles, research conducted on minors, research conducted outside of Canada, articles that are only partially accessible, and lastly, articles that pertain to minor mental illness.

The articles were sourced by conducting a cursory examination of the abstract and conclusion sections to establish relevance. Once the relevance was determined, the articles were then subjected to the inclusion and exclusion criteria. This step substantially filtered down the search results. The next stage in the process was to read through the rest of the article to gleam what research would either be contributory or redundant. This process was performed on each of the 15 chosen articles. The researcher then determined that saturation had occurred as further articles offered no new revelations. This process was difficult as a vast majority of the research in this specific field has been conducted in the United States of America where there is significantly more funding for research. In America, 3.067% of its gross domestic product is directed to research compared to 1.698% of Canada's gross domestic product (Bourque, 2018).

Finally, when dealing with populations such as people with mental illness, it is important to be wary of harmful terminology which could further isolate an already vulnerable group. To avoid any harmful effects, the established terminology for this critical appraisal will be "individuals or people with mental illness" rather than "mentally ill people or individuals". This is not an issue of political correctness but rather about the real effects language has on public tolerance of people with mental illness (Grabmeier, 2016). Although the person-first language is more cumbersome it helps to honour the individual over the disability.

Validity, Reliability and Trustworthiness

To properly weigh the various articles, they have been analyzed according to three basic principles. The first will be the validity of the article. This step involves vetting which individual or institution conducted the primary research and exploring whether they had any potential biases. Next, the trustworthiness of each article was determined by checking the accreditation of the journal that released the article and verifying where the research was conducted. Lastly, the relevance of each article will be judged according to the level of usefulness of the information. The methodology used in Boschma's 2018 article was valid and trustworthy as it focused specifically on quantitative data derived from hospital records from the provinces of British Columbia (B.C.) and Alberta. This article is valuable as it is based on irrefutable quantitative data. It is unfortunately limited in its usefulness to the provinces where it took place as these two provinces were not eligible for federal funding. This means that the deinstitutionalization program was bungled from the beginning due to a lack of financial support. Boschma admits that deinstitutionalization was never implemented properly and so it is challenging to either affirm or deny it as a legitimate alternative to institutional care.

Boyd and Kerrs' 2015 article is valuable and distinct as it is the first of its kind to critically examine reports from an expert police force. The researchers used a framework entitled Foucauldian discourse analysis which presupposes that policy is solely responsible for solving social problems. Though the analysis of the reports was conducted legitimately, the authors only examined four articles from 2008 to 2013 which has the potential to bias the results of this appraisal in two ways. Firstly, the Vancouver Police Department (VPD) may have adapted its language since 2013 to be less problematic and the public would have no way of knowing. Secondly, other mental health initiatives took place over that timeframe which was not discussed such as the highly touted Car 87 program which paired an officer with a mental health specialist.

The purposeful exclusion of these positive VPD initiatives may be indicative of bias on the part of the authors.

Cotton & Colemans' 2010 article is highly credible in terms of trustworthiness and reliability. One of the authors, Dorothy Cotton, has a doctorate in philosophy and is renowned in the field of police psychology. The other author, Terry Coleman, has 40 years of experience in the field of law enforcement. He has also received a doctorate from the University of Regina. One of the strengths of this article lies in how it has affected policy regarding police interactions with SMI. As this paper was published in 2010, many of the suggestions made by Dr. Cotton and Dr. Coleman have since been implemented in the past 12 years. One example is the Car 67 program developed by the Surrey Royal Canadian Mounted Police (RCMP). This program liaises the Surrey RCMP with Fraser Health Authority to provide on-site crises intervention specifically for people with SMI (Royal Canadian Mounted Police, 2020).

The research conducted by Livingston et. al (2011) was well executed. As they conducted a quantitative experiment involving a vulnerable people group, they had to receive approval from the ethics committee of the University of British Columbia and Simon Fraser University. The only notable weakness was the relatively small sample size. The study followed roughly 350 individuals which is minimal when compared to the roughly 800,000 people in B.C. with a SMI (Canadian Mental Health Association, 2022). This limits the applicability of the implications of the study to the general public.

The article by Wilson et al. (2014) is of limited value as it demonstrates a lack of Foucauldian, policy-driven initiatives for people with SMI, but it fails to make any recommendations as to how this issue can be fixed or even further studied.

The article by Crocker et al. (2010) is considered trustworthy as the authors are all affiliated with respected Canadian universities and organizations such as McGill University, the University of British Columbia, and the Royal Ottawa Health Care Group. One weakness within this article is the extrapolation of the results. The author notes this and then proceeds to use the results of one B.C. study as a basis for their claim that the seriousness of any given offence should not determine a Not Criminally Responsible due to Mental Disorder (NCRMD) ruling. The provinces had varying levels of quality of forensic assessment due to financing and, therefore, it is illogical to apply the results from one province to the country as a whole.

The research collected by Sealy and Whitehead (2004) was highly reliable as they aggregated data into standardized, population-based rates so that it could be empirically reviewed. One of the limitations of this study derives from the necessary research method they employed. As the authors' data was gathered at a provincial level, they were unable to determine increases or decreases in in-patient care across facilities meaning that some facilities may have deinstitutionalized far better or worse than the data suggests. Sealy and Whitehead's 2006 study is similarly focused on the difference between when an institution deinstitutionalizes.

Chaimowitz's (2012) position paper is irrefutable in establishing a causal link between deinstitutionalization as a policy and its subsequent symptoms. It covers the history of mental health within Canada from its inception in 1836 to the present. The citations were well documented and there was little personal bias or flagrantly emotive language used.

The research conducted by Jansman-Hart et al. (2011) is incredibly valuable. It unequivocally demonstrates that there has been, overall, an increase in people with a SMI coming into contact with police and thereby the CJS because of narcotic dependence. This article is partially limited in terms of relevance as roughly half of the statistics refer to data conducted in

other countries. It was able to pass through the exclusion criteria as the research was conducted within Canada for the National Trajectory Project by the Mental Health Commission of Canada.

The article by Jayatunge (2013) is somewhat valuable. It does not offer any new insight into the field of psychotherapy but rather amalgamates collections of research. Regardless, the research itself was highly trustworthy and was endorsed by York University which does strengthen its overall worth. This paper reinforces a previously held belief that people with a SMI are at a greater risk for homelessness. Though this does not necessarily add any new information on the topic, it does create a firm base to continue further research.

The article by Reinharz et al. (2003), disclosed the statistics on the cost-effectiveness of the mental healthcare system in Canada. It found that it is incredibly difficult to research the effects of deinstitutionalization on psychiatric patients because the various mental illnesses require vastly different care approaches, which limited the value of the research overall. The article is nonetheless reliable and trustworthy as the researchers are well respected in this field.

Morrow and Jamers' 2007 article is highly trustworthy. They examined narratives of people diagnosed with psychiatric illnesses. This analysis of trauma is incredibly valuable to this field of study as it has been quite limited to date, specifical research with a qualitative focus. The authors are both affiliated with Simon Fraser University which is a university in B.C. with a highly touted faculty of arts and social sciences.

The research conducted by Allison Read (2009) is highly reliable as it was released in the University of British Columbia's Medical Journal which is a respected, award-winning journal that has been in operation since the early 1960s. Additionally, there is no evident bias within the article. Read made some recommendations regarding the possible solutions focused on a collaborative approach balancing independence and support.

The last article included in this critical appraisal is that of Ted Frankel (2003). Frankel's research was significantly valuable as there have yet to be other legal perspectives on the effects of deinstitutionalization. Frankel is Partner at Cassels Brock & Blackwell LLP, a top-tier law firm in Toronto, Ontario. Thus, his interpretations of the legal precedence regarding community-based care are highly trustworthy.

Literature Review

While conducting this literature review, multiple themes emerged. These themes were discovered by grouping common factors found to be consistent throughout the 15 articles. One common theme found within these articles was insufficient trans-institutional psychiatric care. In this context, trans-institutionalization occurs when the impetus for psychiatric care is uprooted from the health care system (HCS) and placed into the sphere of the CJS; either under the purview of the police or the Correctional Service of Canada (Boyd & Kerr, 2015; Boschma, 2011; Cotton & Coleman, 2010; Livingston et. Al, 2011; Wilson et. Al, 2014). As the original intent of the deinstitutionalization was to care for individuals with SMI within the community, trans-institutionalization is an unintended consequence. This results in insufficient psychiatric care due to short stays in correctional facilities which increases the likelihood of recidivism for people with SMI.

Another contributing factor to the criminalization of people with SMI was insufficient to support systems within the community (Crocker et. al, 2010). Deinstitutionalization has exponentially increased the number of individuals with SMI living within the community, a large majority of whom do not have sufficient support structures in place to be successful. One of the original claims about deinstitutionalization was that it was able to quickly reduce operational costs of psychiatric healthcare. Modern research is critical of these arguments and claims that the

cost was simply moved from one budget to another (Sealy & Whitehead, 2004). Lastly, comorbid circumstances such as homelessness and substance abuse were directly linked as contributing factors to the increase in criminalization (Chaimowitz, 2012; Jayatunge, 2013; Jansman-Hart et. Al, 2011).

Insufficient Trans-Institutional Psychiatric Care as a Precursor to Criminalization

One of the rampant contributing factors to the criminalization of mental illness in Canada is the ineffective psychiatric care individuals receive within correctional institutions. Boschma (2011) explored this and found that there is an established causational relationship between deinstitutionalization and an influx of trans-institutionalization which was completely unintentional by policymakers. The author also explored the social impacts due to the aforementioned changes in psychiatric health care. Boschma conducted a case study comparing quantitative demographics of patients at psychiatric institutions in B.C. and Alberta from the 1950s to 1980s and found that there was an enormous increase in the discharge rates. The Alberta Hospital Edmonton patient count reduced from 1,239 patients in 1946 to 662 patients in 1976. During that same period, short-term admission increased from 103 in 1946 to 1,822 in 1976, an increase of 1,668%. The increase in short-term admissions was most prominent amongst individuals with a SMI. Boschma thus deduced that the intertwined process of trans-institutionalization overshadowed the original altruistic ideals of the deinstitutionalization movement.

This finding was consistent with other research such as that conducted by Boyd and Kerr (2015). The authors synthesized the results of four VPD policy reports into a single case study on Vancouver's mental health crisis. The timeline of these reports spans from 2008 to 2013 and covers both qualitative and quantitative data. It found that the VPD officers, who are now at the

forefront of the deinstitutionalization crisis in B.C., have essentially replaced health care workers as the primary point of contact for individuals with mental illness, shifting the institutional dependency from the health care sphere into the criminal justice sphere regardless of whether the frontline workers were properly trained. Boyd and Kerr (2015) also noted that when the police replace psychiatric doctors and nurses, victimization is inevitable. Through the VPD's newfound responsibility, they have developed new, standardized police tactics on how to best serve individuals with mental illness, such as partnering officers with mental health professionals or dedicating a specific unit to mental health calls. Because of this expertise, the public and policymakers place significant weight on the findings reported by the police. Another major finding was that the overall language used and framing of SMI within the reports had contributed to stigma and criminalization by over-emphasizing the dangerousness of people with mental illness. Boyd and Kerr believe the reports contribute more to social control rather than to the betterment of the lives of people living with SMI in Vancouver.

Cotton & Coleman, 2010 used a systems theory approach to study the delicate sub-systems of health care and policing. The authors investigated the often-confrontational relationship between persons with a severe mental illness (SMI) and the police services of Canada. This article used mixed methods results to aggregate the results to their research topic. The authors suggest various guidelines for police to improve their interactions with individuals who have SMI. These guidelines include designating certain officers to receive training and handle all mental health calls, establishing official liaisons between the two sub-systems, developing assessment methods to be employed on a case-by-case basis, collecting data to inform interactions and making mental health information available for officers. These

recommendations were all made based on the noted weaknesses found within the current training practices.

Livingston et al. (2011), used a naturalistic, retrospective cohort design, to compare two groups of patients discharged from forensic psychiatric facilities. The first group was discharged before realignment and the second group was transferred after realignment. Realignment is a term coined by the authors that refer to the recent devolution of tertiary psychiatric care facilities. Propensity score matching was then used to estimate the results over two years following the patients' discharge. The authors note that most patients in both cohorts (before and after realignment) were not transferred to other sectors after discharge. The authors conclude that the deinstitutionalization movement of the 1960s was a failure due to poor planning, lack of funding and lack of understanding of the needs of individuals with SMI. The authors argue that deinstitutionalization was limited by how its services were delivered. The rate at which traditional psychiatric facilities emptied outpaced the capacity for in-community care. Though Livingston et al. agree that historically, deinstitutionalization has been a failed policy, they argue that through careful implementation of policies, the deleterious symptoms can be effective.

The final article focused on the development of trans-institutionalization is that of Wilson et al. (2014). They focused specifically on the subset of individuals with SMI that have been found guilty of sexual assaults with the hypothesis that this subset of people with SMI is specifically stigmatized and therefore receives worse treatment. Their research corroborates other findings in that prisons have replaced both in-community care and psychiatric institutional care. The authors used vignettes which are short, qualitative-based stories based on interviews they have conducted with people with SMI who have also committed sexual crimes. Additionally, they gathered qualitative, secondary data to extrapolate and analyze the results of

their interviews. The authors found that their original hypothesis was refuted and that regardless of whether an individual with SMI has committed a sexual crime or not, they are consistently at risk of being mistreated.

Insufficient Support Systems Within the Community

Another common theme found within the literature that contributed to the criminalization of mental illness was the prevalence of poor social support structures within the community. There has been a consistent increase in demand for forensic mental health services in Canada. The vacuum created by deinstitutionalization has never been adequately remedied by in-community practices. Some of the leading causes are poor support for people with SMI due to a lack of close family or friend relationships. This lack of support led to isolation which, in turn, resulted in a steady increase of charges laid against individuals with SMI which has effectively criminalized people with a mental illness for having a mental illness (Boyd & Kerr, 2015).

Crocker et al. (2015), studied discrepancies in the forensic evidence used in court outcomes of NCRMD. This research was conducted in Canada in 2010 and amalgamates court rulings from Quebec, B.C. and Alberta as those three provinces are responsible for the majority of NCRMD cases. This article uses quantitative research to support its claims. The authors argue that systematic deinstitutionalization has made voluntary admissions to psychiatric facilities far more difficult which has thus, created a gateway for individuals with SMI to receive care within the CJS.

Chaimowitz et al. (2012) also found evidence that supports a hypothesis of an earlier sociologist P.L. Penrose, who claimed in 1939 that there exists an inverse relationship between prison and mental hospital populations. Essentially, if one is decreased, the other will automatically increase. 100 years after Penrose's initial hypothesis, Chaimowitz's research has

affirmed it. Ineffective in-community care has directly led to the uptick of prisoners with SMI thus, establishing Penrose's hypothesis as a reality. This article is incredibly valuable for those who propagate the re-institutionalization of people with SMI though, as it is a position paper, it refrains from offering any counter-arguments which weakens its overall legitimacy.

A comparative study conducted by Sealy and Whitehead in 2006 found that the quality of social support systems is decreasing over time. They interestingly note that psychological distress increased in individuals who experienced deinstitutionalization later on in the process (1998/1999). According to the authors, the effectiveness of deinstitutionalization has antithetically worsened over time. They recommend further research be conducted to determine why.

Finally, the article by Ted Frankel (2003) is conducted from a legal perspective. Frankel argues that disabled individuals have an inherent charter right to community-based care. By analyzing the various legal case studies, Frankel found that statutory laws such as the hospital act and the income assistance act offer some support to people with SMI but, they are insufficient in preventing them from defaulting on the CJS. He concludes by arguing that the current system is a complete failure that has left those with SMI wandering in the desert alluding to the biblical story of the Israelites wandering the desert for forty years found in Exodus 13.

Proclaimed Economic Benefits

The research paper conducted by Sealy & Whitehead (2004) assessed the installment of deinstitutionalization in Canada, which was implemented for two main reasons (according to the researchers): the financial burden of institutional care and the legal issues associated with institutions. One of the goals of deinstitutionalization was to vastly reduce the cost of psychiatric care. Rather than investing in sufficient social programs to keep people with SMI accountable

and supported in society, the federal government instead opted to spend as little as possible. This resulted in short-term savings in the HCS at the expense of long-term economic losses through the mounting costs of the CJS. The researchers conducted a quantitative study where they measured and then compared four different aspects of deinstitutionalization. The aspects were: how many beds each psychiatric institute maintained, the duration of the patients' stay in those beds, the duration of a patients' stay within general hospitals and lastly, the expenditure on psychiatric services per capita. They determined that the rollout of deinstitutionalization was vastly different throughout the provinces.

Both quality, expediency and intensity of deinstitutionalization varied. They also found that nationwide psychiatric inpatient numbers decreased by 70.5% from 1965 to 1981. Canada-wide psychiatric costs then skyrocketed from $6.97 million in the late 1980s to $35.9 million by the year 1999. This implies that the financial benefits of deinstitutionalization were grossly overestimated. Contrarily to other research, a cost-effectiveness analysis of psychiatric deinstitutionalization found that when conducted properly, the outcome of deinstitutionalization is generally positive for the psychiatric patient at a lower cost to the taxpayer (Reinharz et al., 2004). Notwithstanding the prior, the authors concede that the majority of deinstitutionalization policies have not been implemented properly.

Comorbid Circumstances Such as Homelessness and Substance Abuse

Homelessness and substance abuse were commonly found to act as precipitating factors bringing people with SMI into contact with police and thereby the CJS. Jansman-Hart et al. (2011) compare the effects of the deinstitutionalization movement in Canada to that of other nations that have also opted for this form of psychiatric care such as the United States, England, Germany and other western European countries. The researchers employed mixed-method

research to compare and contrast the similarities between Canada and other Western countries that have also embraced deinstitutionalization. They noted the rate of growth of the NCRMD population in Canada increased by 2,500 from 1992 to 2004 and was expected to increase exponentially to 4,500 by 2015. The deinstitutionalization movement has led to the forensication of the mental health system in Canada. Forensication is a term coined by the authors that refer to the significant increase of persons with SMI who enter the CJS. Furthermore, the authors refuted common theories that there are simply more individuals with severe mental illness or that persons with mental illness have become more violent over time. Instead, the data indicates that the increasing demands on forensic admission are more closely tied to the greater use of narcotics. Increased substance reliance comes as a result of deinstitutionalization and lack of access to legitimate pharmaceutical-grade medication. The following articles have also concurred with this finding.

Chaimowitz developed a position paper for the Canadian Psychiatric Association in 2011 and posited that the deinstitutionalization movement of the 1950s and 1960s was directly tied to the advent of psychotropic drugs. Essentially, the psychotropic drugs mitigated dangerous outbursts from people with SMI so that they were able to safely return to their community but when that medication ran out, individuals with SMI resorted to cheaper street-level alternatives. This both worsened their mental state and placed them into direct contact with the police.

However, instead of substance abuse, Read's 2009 article argues that homelessness is the premier negative symptom of deinstitutionalization. Read argues that funds saved by the policy of deinstitutionalization were not reallocated to housing policies for people with SMI which increased homelessness. Presently, it is estimated that 35% of homeless people now suffer from mental illness and over 50% have a co-existing drug or alcohol addiction. The lack of long-term

housing policies within Canada has significantly afflicted this subset of individuals with a dual diagnosis of psychiatric illness and substance addiction.

Morrow & Jamer (2007), took a different approach to their research wherein they focused less on the changes to the HCS and more on the effects of losing control over one's life. They determined that deinstitutionalization, specifically in the B.C. context, has created severe housing shortages (due to soaring real estate costs) which has limited individuals' ability to move freely in the community and live independently. The continued lack of social support has limited people with SMI's ability to access three basic citizenship rights "housing, income and education" (Morrow & Jamer, 2007, Discussion section). Both income and education are two interconnected themes that require further research.

Lastly, regarding homelessness, Jayatunge's 2013 article highlights the lack of a national housing policy by the Government of Canada and how that has resulted in an increase in homelessness amongst individuals with SMI. This paper relies on secondary qualitative research gathered from existing research conducted by governmental agencies such as the United Nations and the Mental Health Commission of Canada. Mental health and homelessness have an intertwined relationship within the Canadian context. While unable to cope and lacking traditional medicines, homeless people with SMI tend to rely on various other coping methods such as drugs and alcohol. This addition further contributes to the staggering mortality rates amongst the Canadian homeless. The aforementioned authors suggest that the main method for reducing the over-stigmatization and criminalization of this comorbid group is supportive housing. This would allow those with SMI long-term psychosocial rehabilitation which would better equip them to rejoin their communities.

Critical Appraisal

Gender Disparity in Psychiatric Research

Modern research has struggled to conduct quantitative research studies involving patients with SMI due to the vulnerability of the group, the decentralized nature of deinstitutionalization and the incompatibility of certain illnesses. This admitted gap in research becomes even more noticeable when attempting to source data that specifically focuses on the female experience. Boschma (2011) noted that this was not always the case. One of the benefits of institutionalization was that it created an environment for research to flourish, such as the Greater Vancouver Mental Health Service which used to operate both short-term and long-term facilities specifically for women.

Presently, one of the few areas where research can still be conducted is within the correctional facilities of Canada. Roughly 30% of female inmates within correctional facilities suffer from some form of psychiatric ailment which is over double that of men (14.5%) (Chaimowitz, 2012). This suggests that females are more likely to be criminalized than their male counterparts. Additionally, the comorbid subgroup of homeless women with a SMI is at severe risk for victimization. Some studies have found that upwards of 75% of homeless single women have a psychiatric diagnosis which is particularly worrisome as this sub-group is roughly 10 times more likely to die than women in general (Jayatunge, 2013).

It is important to be able to study the two genders independently as applying male results to a female population risk generating false assumptions. Marina and Brenda (2007) note that men and women experience mental illness differently due to their varying social experiences. As mental illness afflicts men and women differently, the natural inference drawn is that the reactions surface in different ways as too. For instance, women are more likely to develop anxiety and depression diagnoses whereas men trend toward SMIs such as antisocial disorders

(American Psychological Association, 2011). Some symptoms of SMI are more violent than others and therefore at a higher risk of criminalization.

Sealy and Whitehead (2004) noted one commonality amongst the genders when studying their interactions and dependence on social support; lower levels of social support led to increased psychological distress in both males and females. Even the research that included differentiation between the genders did not study sample sizes large enough to extrapolate and apply any credible results. For example, the study conducted by Marina and Brenda only covered nine women and eight men. The overall consensus is that further research needs to be conducted focusing specifically on women.

Political Influences in the Implementation of Deinstitutionalization

Another consistent issue found in the literature was the process by which deinstitutionalization was implemented in various provinces. Externally, deinstitutionalization was professed to be an altruistic and humanitarian transition towards a more progressive health care system. In actuality, the rollout of deinstitutionalization was a process "fraught with political controversy as well as continued funding constraints that continued well into the 1990s" (Boschma, 2011, p. 253). Cost containment was often the point of political contention wherein individuals with SMI became the secondary focus. This contributed to inadequate social services where support was not offered on weeknights or weekends, a common time for psychotic issues to arise (Boschma, 2011). As the impetus for deinstitutionalization was in part to reduce costs, Sealy and Whitehead (2004) studied operational costs of psychiatric hospitals per capita over time. They found that the cost increased Canada-wide. In 1970, the cost increased from $4.84 per patient per day to $23.45 per day in 1980. Interestingly, these cost increases were inconsistent across different provinces. Saskatchewan decreased its cost per capita over that same timeframe. This indicates that the cost

commitment to deinstitutionalization varied depending on the HCS of each province. An additional conclusion the authors found is that the effectiveness of deinstitutionalization directly influences the likelihood that an individual resorts to criminal activity.

Another political sphere that influences deinstitutionalization is public support. Presently, the political pendulum has shifted from supportive to opposed, specifically in Vancouver, B.C. The visible nature of the impacts of deinstitutionalization, such as increased homelessness, substance abuse and criminality, has become so apparent that the general public has shifted its view and is now pressuring the psychiatric community for re-institutionalization (Boyd and Kerr, 2015; Jansman-Hart et al., 2011; Jayatunge 2013). The current societal zeitgeist in Canada emphasizes a dignified healthcare response to people with SMI; so long as it remains out of the purview of the public. Frankel (2003) argued similarly that the Canadian court system has been reluctant to interfere in policymaking surrounding de-institutional health care despite how poorly the provincial governments have implemented community care. Thus, people with SMI have been at the whim of whichever political argument is popular at the given moment.

Substance Abuse as a Contributing Factor Rather Than a Symptom of Deinstitutionalization

The relationship between deinstitutionalization and substance abuse is another area of research that requires clarification. As previously noted, the advent of psychotropic drugs, such as chlorpromazine in the 1950s, made deinstitutionalization possible (Boschma, 2011; Morrow & Jammer, 2007). These drugs mitigated the more severe outbursts but came with serious addictive side effects that were not properly tested. For example, some research indicates that the dependence on illicit drugs is a result of people with SMI being unable to obtain legitimate

psychotropic medication (Read, 2009). Others argue that certain drugs catalyze a deterioration in mental faculties thus, worsening the mental illness itself (Jansman-Hart et al., 2011).

The research that is critical of the deinstitutionalizations of dependency on psychotropic drugs argues that "many who have been in the health care system… have often failed to recognize that community support and nurturing are as essential, or more essential, to well-being than all the world's psychotropic drugs" (Frankel, 2003, p.32). This is essentially a "chicken or the egg" paradox where it becomes impossible to clarify cause-and-effect relationships. This is important in terms of evaluating criminalization. If quantitatively proven, Canada has effectively criminalized mental illness using psychiatric hospitals to create substance reliance for an entire generation of people with SMI and then released them into the community with insufficient support. The effects of drug withdrawal are well documented and lead many to engage in criminal activity as an avoidance behaviour.

Discussion

In continuing the objectives of this critical appraisal, recommendations for future research must be conducted. For this purpose, gaps in the current literature were examined in the previous sections. Some of the consistent themes that arose were the inconsistencies in gendered research, the political influences of deinstitutionalization and the paradoxical relationship between mental illness and substance abuse. These common themes all have inherent problems that may have contributed to the criminalization of people with SMI. Out of these isolated problems emerged recommendations for future research.

Comorbid Approaches to Psychiatric Care

Comorbidity, in the context of mental health, occurs when there are simultaneous disorders co-existing within one single patient (Klykylo, 2002). The comorbidity of SMI,

substance abuse and homelessness have contributed to a social environment conducive to criminalization (Cotton & Coleman, 2010; Chaimowitz, 2011). The research has thus far thoroughly examined each aspect independently, but it has yet to examine mental illness, drug addiction and homelessness as essential aspects of the same disorder. As previously mentioned, drug addiction worsens disorders for people experiencing psychosis (Canadian Mental Health Association, 2018). This area of research requires specific attention as this sub-group of people is at a specific risk for both victimization and criminalization. Boyd and Kerr (2016), used the example of Vancouver's Downtown Eastside (DTES), an area notorious for mental health issues and substance abuse, as a microcosm of criminalization and victimization when they wrote:

> [the people living in the DTES are often] victims of predatory drug dealers, abusive pimps and unsavoury landlords who take advantage of their vulnerabilities. Unable to access reasonable mental health and/or addiction services, people are frequently coming into contact with VPD officers who in turn rely on provisions in the Criminal Code in the absence of an acceptable response from hospitals to admit mentally ill patients (p.423).

The current research is hyper-focused on individual symptoms of deinstitutionalization. This approach fails to recognize that mental health is a highly intricate and interconnected field where research should not be conducted in isolation. Further research into this specific area should be focused on holistic practices that better care for comorbid patients.

Re-Implementation of Institutional Care

Institutionalization is a possibility often espoused by contemporary research (Boyd & Kerr, 2015; Read, 2009). The basic premise is that all psychiatric healthcare ought to be within the scope of specialized psychiatrists within permanent housing facilities known as asylums. This practice was originally in place en masse before the de-institutionalization movement of the

1960s. As was previously mentioned, the increased recognition of the symptoms of deinstitutionalization has galvanized the general public against the in-community care model (Read, 2009). Further research should be conducted on the benefits of re-institutionalization before any such policy shift is carried out. It is important to remember that institutionalization was originally replaced, at least in part because it was considered inhumane. Therefore, the research would focus on learning from the mistakes of the previous regime to ensure the asylums would be beneficial for individuals with SMI.

The criminalization of mental illness has also increased at different rates in each province regardless of the federally legislated Criminal Code of Canada that Canadian police enforce (Crocker et al., 2010). This type of discretionary police action taken against people with SMI is reflected in the social beliefs prominent in the majority of the provincial community. As noted by the empirical assessment (2004) and subsequent analysis (2006) of Sealy & Whitehead, deinstitutionalization was implemented in two phases. First, a mass exodus of people with SMI into the community, then the slow implementation of psychiatric health services over the next 40 years. The provinces of Manitoba, Quebec, Prince Edward Island, New Brunswick and Newfoundland were all found to be far slower in implementing effective deinstitutionalization than others (Sealy & Whitehead, 2006). This resulted in more psychological distress and subsequent contact with police. Further research on the validity of the re-institutionalization should focus on overcoming the provincial disparities to ensure consistent healthcare.

Validating In-Community Psychiatric Care

One of the major issues with the system of deinstitutionalization in Canada is the lack of validation by government officials on the progress of individuals with SMI in their attempts to merge with the general society. Evidently, the lack of accountability has resulted in displacement

rather than integration. Wilson et al. (2015) determined that the lack of meaningful consequences for people with SMI directly leads to negative outcomes such as engagement with the CJS. They recommend implementing supervisory systems that focus on balancing the community risk with the freedom that individuals with SMI need to integrate successfully. Interestingly, they also determined that a contributing factor to the failure of de-centralized success is the individuals employed in a supervisory role themselves. Rather than viewing themselves as fundamentally different from the individual with mental illness, it is important to recognize that, according to self-determination theory, all humans seek autonomy, relatedness, competence, and a sense of purpose. According to Wilson et al. (2015), assuming that individuals with SMI are fundamentally different from those without SMI decreases the likelihood of integration and thereby increases the likelihood of engagement with the CJS.

Recommendations

This critical appraisal has highlighted blatant gaps in knowledge that need to be further researched as policymakers decide what version of psychiatric health care would be most effective in the future. The critical appraisal process determined that further research should focus on three lacking areas. Specifically, gender disparity in psychiatric research, political influences in the implementation of deinstitutionalization and substance abuse as contributing factors rather than symptoms. As the criminalization of mental health continues, these areas of research would benefit law enforcement in two main capacities.

Firstly, research conducted on the differences between the genders and the implications of substance abuse on SMI would better equip officers as they respond to ever-increasing numbers of mental health-related calls. The occurrences of Mental Health Act calls responded to by the Royal Canadian Mounted Police have increased from 29,667 in 2010 to 88,460 in 2020

(Royal Canadian Mounted Police, 2020). That represents an increase of almost 200% in a single decade. Improving the engagement between the police and those with SMI in Canada would simultaneously restore confidence and trust in the police which is necessary for effective policing and preventing the criminalization of mental illness (Schapp, 2019). Further study in these areas would also have implications for the law enforcement community.

Research conducted on the political influences in the implementation of deinstitutionalization would benefit law enforcement on a macro-level to combat stigmatization of those with SMI. As psychiatric care is a provincial responsibility, it is important to prioritize healthcare over criminalization regardless of political affiliation. Jenny Yang (2022) determined that the provincial disparity in mental health expenditures is extreme; $18,114 per capita in the Northwest Territories compared with $5,042 in Ontario. Overcoming the mental health endemic in Canada depends on the solutions offered by the dominant parties on the political spectrum. Conservative parties traditionally focus primarily on crime control methods whereas Liberal governments are typically concerned with preventative solutions. Research conducted on the political influences on psychiatric healthcare would better guide policymakers in the future.

Conclusion

Deinstitutionalization remains the most impactful shift in Canadian psychiatric care to date. This critical appraisal has definitively determined that, during the past 25 years, the deinstitutionalization movement has inadvertently criminalized mental illness in the Canadian CJS. The tripartite relationship between homelessness, substance abuse and SMI was also explored. By examining 15 modern articles, the researcher found that deinstitutionalization as a mental health strategy can be effective but, due to the provincial inconsistency in community support, a lapse in care for comorbid patients and poor trans-institutional psychiatric care, it has

contributed to the criminalization of people with SMI in Canada. Additionally, the proclaimed benefits of deinstitutionalization, such as cost-effectiveness and humaneness, failed to materialize. Evidently, the applicability of this finding is limited to the Canadian context. The post-modernist approach utilized in this critical appraisal sought to study the phenomenon of criminalization of those with SMI in a holistic manner. As such, there are various weaknesses in Canadian research that are not actively being studied and therefore were not included in this critical appraisal, such as how education and income influence the probability of criminalization. In its current state, deinstitutionalization has been a failed experiment in Canada though, whether it is a redeemable psychiatric health care alternative is still in contention.

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