Criminalization of the mentally ill

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In the great world of "they sayers," they say that the more things change, the more things stay the same. Over a decade ago, Peplau (1994), affectionately known as the mother of psychiatric nursing, observed that the first great psychiatric revolution, and the beginning of contemporary psychiatric nursing, occurred when patients were moved from jails to asylums, and from asylums to hospitals. Regrettably, for a variety of reasons and life circumstances, countless consumers of traditional mental health services increasingly find themselves seeking mental health care under the auspices of jails, prisons, and correctional facilities – a phenomenon frequently referred to as the criminalization of the mentally ill.

The deinstitutionalization movement that began in the 1960s, reached its peak in the 1970s, and continues today in some jurisdictions has often been blamed for the criminalization of the mentally ill. And although the philosophical underpinnings of deinstitutionalization were admirable, critics have declared that the "deinstitutionalization of seriously mentally ill individuals has been the largest failed social experiment in twentieth century America" (Torrey, 1995, p. 1612). Unfortunately, the persistent lack of appropriate mental health policy for indi-

viduals with chronic mental illness, coupled with insufficient community-based services, resulting in a lack of timely access to assessment and treatment, has resulted in a fragmented mental healthcare system. Many individuals with mental illness are not able to access appropriate and timely treatment; many have co-occurring substance abuse disorders and engage in criminal activities to support their drug habits; whereas others have long histories of committing crimes of survival (Human Rights Watch [HRW], 2003). Regardless of the scenario, they find themselves being bounced between courts, jails, and prisons – a process known as transinstitutionalization (Slovenko, 2003). Sadly, correctional facilities have become "front-line mental health providers" (HRW, 2003, p. 16), representing the "mental health institutions of the 21st century" (White & Whiteford, 2006, p. 302).

A recent study by the United States Department of Justice reported that 479,000 local jail inmates (64% of their total population), 705,000 state prisoners (56% of their total population), and 78,000 federal prisoners (representing 45% of their total population) present with symptoms of serious mental illness (i.e., schizophrenia, bipolar disorder, and depression) (James & Glaze, 2006). And although these numbers are particularly staggering, similar trends have been reported in Canada and the United Kingdom as well.

Conventional wisdom would dictate that prisons were never designed to meet the needs of individuals requiring treatment for mental illness, and controversy exists regarding how well-equipped prisons are to deal with the complex needs of mentally ill offenders. All too often,

those with mental illness have difficulty comprehending prison rules and following orders. Many are victimized and tormented by other inmates, and endure beatings and sexual assaults. Correctional staff are often cast into the role of front-line mental health workers, even though they have limited understanding of mental illness and lack adequate resources to intervene appropriately. All too often, in misguided attempts to keep those with mental illness safe, the inappropriate use of segregation, seclusion, and restraints prevails, which contributes to further decompensation of their physical and mental well being. These observations are best summarized in the poignant words of a mother (whose son has bipolar disorder), as documented in *Out of the shadows at last: Transforming mental health, mental illness, and addiction services in Canada*, the final report of the Standing Senate Committee on Social Affairs, Science, and Technology (2006):

> . . . incarcerating mentally ill people in jails and prisons is cruel, unjust, and ineffective. Prisons do not have adequate or appropriate facility resources or medical care to deal with the mentally ill. Poorly trained staff is unable to handle the difficulties of mental illness. The mentally ill suffer from illogical thinking, delusions, auditory hallucinations, paranoia, and severe mood swings. They do not always comprehend the rules of jails and prisons. They are highly vulnerable and prone to bizarre behavior that prison staff must deal with and inmates must tolerate. (p. 300)

Diversion from incarceration

In recent years, in an attempt to provide more humane, cost-effective mental health care, some jurisdictions have adopted diversion schemes whereby individuals with mental illness who have come into conflict with the law are diverted to treatment programs, mental health courts, or both. Such diversion schemes have been found to be particularly beneficial for those whose crimes are nonviolent in nature, and are not committed with criminal intent (HRW, 2003; Munetz & Griffin, 2006). The diversion schemes, although relatively new, have been in practice in the United Kingdom since the early 1990s (Turnbull & Besse, 2000). Their use in Canada and the United States varies, as does their effectiveness, which depends a great deal on both the availability and the type of diversion program in practice (e.g., with the police, upon arrival to court, or upon initial detention) (HRW, 2003; Steadman et al., 2001; Trupin & Richards, 2003).

A new model of service delivery, forensic assertive community treatment, is emerging as a form of diversion for individuals with histories of severe mental illness and involvement with the criminal justice system. The goals of forensic community assertive treatment are twofold: to prevent the arrest and incarceration of this highly vulnerable population by integrating assertive community treatment with community justice initiatives. Unfortunately, continuing program refinement and research are compromised by limited funding resources (Lamberti, Wesiman, & Faden, 2004). More recently, Munetz and Griffin (2006) have advocated for the use of a sequential intercept model, one that envisions five points of interception, from law enforcement through to community corrections and support, as a way of preventing individuals from either entering or penetrating deeper into the criminal justice system. And, although collectively, the diversion schemes represent a relatively new approach to working with individuals with mental illness who come into conflict with the law, they hold much promise for not only humane treatment of mentally ill offenders, but perhaps more importantly, they hold the promise of recovery and reduced recidivism among this population (HRW, 2003; Munetz & Griffin, 2006).

What role will forensic nurses play?

Forensic nurses, who work with mentally ill offenders, practice at the shifting interface of the criminal justice system and the healthcare system, and their ability to provide competent and ethical nursing care is often compromised by personal, social, and political animosity regarding crime, criminality, and mental disorder. Prior to the late 1960s, very few nurses gave much thought to working with offenders in correctional environments. Since then, nurses have slowly and methodically embraced a multitude of professional roles in their quest to provide offenders with quality nursing care. Yet many questions beg to be answered. What are the best models of mental health service delivery for individuals caught in the web of transinstitutionalization? What knowledge and skills are required to provide competent and ethical nursing care in restrictive correctional environments? How does one best advocate for the mentally ill offender? Can correctional staff and nursing staff achieve a mutually agreeable model regarding the provision of mental health care? Appelbaum, Hickey, and Packer (2001) have asserted that correctional officers, in collaboration with mental health professionals, have important responsibilities when working with this vulnerable group. Correctional officers, however, cannot and should not be replacing nurses; instead, forensic nurses should be advocating for mental health care that is consistent with the community standard. Are there roles for nurses in relation to social health policy for those who are diverted? What about those who are incarcerated? If so,

what might those roles be? Clearly, forensic nurses cannot sit back in a state of complacency, simply content with the *status quo*. They need to collaborate with others to ensure appropriate changes to legislation, which continues to criminalize individuals in need of mental health treatment.

Through the accumulation of knowledge acquired by explorations in theory, practice, and research in community and prison environments, forensic nursing will continually grow and evolve in response to the needs of offenders and the public at large. In short, forensic nurses, like all nurses working with and advocating for vulnerable populations, "need to become champions for what they do and to make their work visible" (Erlen, 2006, p. 135).

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