1 JUSTICE AND INJUSTICE
A Brief History of Mental Health and Justice in Canada

LEARNING OUTCOMES

After reading this chapter, you will be able to:

- Understand and use a variety of terms from the various helping professions.
- Discuss how mental health was perceived in Canadian history.
- Recognize distinct eras of mental health response in North America and identify the challenges and improvements made in each era.
- Discuss adaptations and improvements that have occurred in response to mental health in the justice system and society.
- Critically assess the pros and cons of a mental health diagnosis and the *Diagnostic and Statistical Manual of Mental Disorders*.
- Critically assess the efficacy of anti-stigma efforts.

Introduction

first responders
all law enforcement officers, firefighters, paramedics, correctional staff, search and rescue personnel, dispatchers, and nurses

justice system
all professions related to the administration of the law and the criminal justice system, including police, attorneys, paralegals, court workers, probation officers, and so on

multidisciplinary team
an approach in which professionals from a variety of professions work together with an individual on a topic or a specific set of problems

This chapter will explore the ways in which the helping professions, **first responders**, and the criminal **justice system** in Canada have attempted to adapt to the ever-changing awareness of mental health issues.

Canadian mental health statistics will be looked at to provide a baseline understanding of the scope and magnitude of mental health issues in Canada.

We will explore some of the differences and commonalities among the various professions that work together to improve individual and community mental health outcomes, with an eye toward practical advice for **multidisciplinary teams**.

A brief history of mental health eras relevant to the Canadian context surrounding institutionalization and deinstitutionalization will also be provided.

The last part of this chapter will look at how diagnoses have evolved and how they can help or hinder individuals living with mental health. We will look critically at the history of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and other attempts to diagnose mental illness.

It is important to examine the history of societal responses to mental health problems in order to develop an understanding of how to respond to mental health issues. This will lead us into the next two chapters, where we will explore more current developments in the helping professions.

Today's Approach

> Canada's inattention to the promotion of mental health and its tendency to devalue and segregate (physically and socially) those who experience mental illness has deep historical roots.
>
> —Archibald Kaiser (2008)

Our approach to mental health today in our public service systems, including first responders and the justice system, is built on a history of prejudice, misunderstanding, and ignorance about mental health and how it affects individuals, families, and communities.

At the same time, these systems have taken steps to evolve and adapt to the challenge of treating those living with mental illness fairly under the law and effectively in the health care system. Society's understanding of these issues has grown, and yet many of the positions taken by the helping professionals have, for better or for worse, generated great interest from the general public.

There is a fascination with mental health issues in our policies, in pop culture, and in news media. Stories about those who live with mental health issues have permeated the consciousness. We've all seen representations of mental illness as the motivator for the villain in a horror movie or read extreme stories of violence perpetrated by a few people living with mental health problems.

What we don't see as often—although improvements are being made—are the stories of the vast majority of those living with mental health issues who strive and cope.

Taking a look at statistics will help give us a better sense of the scope of mental health issues in Canada than looking at select media reports or pop culture portrayals. According to Statistics Canada, in 2012, 10.1 percent of the population over the age of 15 (2.8 million Canadians) had "symptoms consistent with at least one of the following mental or substance use disorders: major depressive episode, bipolar disorder, generalized anxiety disorder, and abuse of or dependence on alcohol, cannabis or other drugs" (Pearson et al., 2013).

The same report looked at lifetime rates for mood disorders or substance use disorders. It found that 3.5 million Canadians met the criteria for living with a mood disorder in their lifetime, while nearly 6 million Canadians met the criteria for substance use disorders in their lifetime (Pearson et al., 2013).

DISCUSSION QUESTIONS

1. Can you list three negative portrayals of a person living with mental health that you have seen in popular culture? Can you list three positive examples?
2. Try to find three positive examples of real-life stories of people living with mental health challenges. Can you find three negative or tragic examples?
3. What effects might decades of negative media portrayals of people who live with mental health issues have on us?

This means that in 2012 (the most recent census data available on the subject), one in three Canadians (9.1 million people) met the criteria to have one of six mental health or substance use disorders in their lifetime. See Table 1.1 for a more detailed breakdown of this information (Statistics Canada, 2012).

TABLE 1.1 Rates of Selected Mental or Substance Use Disorders, Lifetime and 12-Month, Canada, Household Population 15 Years of Age and Older, 2012

SELECTED DISORDERS	LIFETIME	12-MONTH
	%	
Mental or substance use disorders[1]	**33.1**	**10.1**
Substance use disorder[2]	21.6	4.4
Alcohol abuse or dependence	18.1	3.2
Cannabis abuse or dependence	6.8	1.3
Other drug abuse or dependence (excluding cannabis)	4.0	0.7
Mood disorder[3]	**12.6**	**5.4**
Major depressive episode	11.3	4.7
Bipolar disorder	2.6	1.5
Generalized anxiety disorder	8.7	2.6

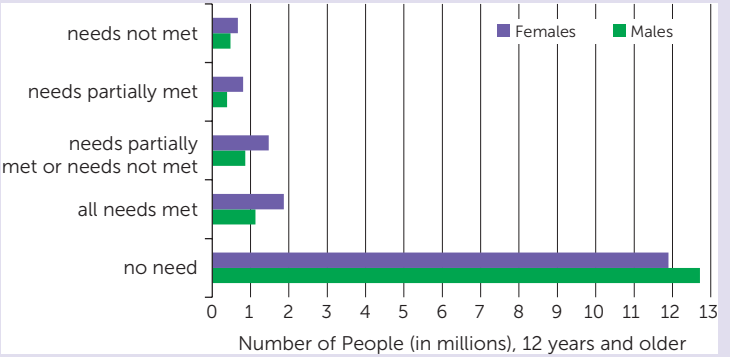
NOTES:

1. **Mental or substance use disorders** comprise substance use disorders, mood disorders, and generalized anxiety disorder. However, these three disorders cannot be added to create this rate because these three categories are not mutually exclusive, meaning that people may have a profile consistent with one or more of these disorders.
2. **Substance use disorder** includes alcohol abuse or dependence, cannabis abuse or dependence, and other drug abuse or dependence.
3. **Mood disorder** includes depression (major depressive episode) and bipolar disorder.

Source: Statistics Canada, 2012.

While Statistics Canada has yet to release a full update since 2012, the agency has compiled some related statistics that are relevant. These give us some insight on the perceived need for mental health care in Canada and how often those needs are met, as well as information about what percentage of all deaths in Canada are caused by mental health and behavioural disorders. See Figure 1.1 and Table 1.2.

FIGURE 1.1 Perceived Need for Mental Health Care in Canada, 2018



Source: Statistics Canada, 2019.

TABLE 1.2 Mental Health–Related Deaths in Canada, 2019

CAUSE OF DEATH (ICD-10)[1,2]	EXAMPLE(S)	TOTAL, ALL AGES, BOTH SEXES[3,4]
Organic, including symptomatic, mental disorders	Alzheimer's disease, dementia	24,099
Mental and behavioural disorders due to psychoactive substance use	Acute intoxication, dependence, withdrawal, psychosis, and amnesia, related to substance use	1,090
Schizophrenia, schizotypal, and delusional disorders	Schizophrenia, psychotic disorders	109
Mood [affective] disorders	Bipolar affective disorder, depressive episode	148
Neurotic, stress-related, and somatoform disorders	Anxiety disorder, obsessive-compulsive disorders, post-traumatic stress	10
Behavioural syndromes associated with physiological disturbances and physical factors	Anorexia nervosa, insomnia, sexual dysfunction	14
Disorders of adult personality and behaviour	Paranoia, compulsive gambling, pyromania, paedophilia	7
Mental retardation	Approximate IQ below 70 (in adults, mental age from under 12 years)	46
Disorders of psychological development	Autism, Asperger's syndrome	27
Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	Oppositional-defiant disorder, tics, bedwetting, stuttering	0
Unspecified mental disorder	Any disorders not included in the above categories	1

NOTES:

1. Classifications are based on the World Health Organization (WHO), International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10).
2. The cause of death tabulated is the underlying cause of death. This is defined as (a) the disease or injury that initiated the train of events leading directly to death, or (b) the circumstances of the accident or violence that produced the fatal injury. This underlying cause is selected from a number of conditions listed on the death registration form.
3. Counts in this table exclude deaths of non-residents of Canada.
4. 2019 data for Yukon are not available.

Source: Statistics Canada, 2020.

DISCUSSION QUESTIONS

1. What might the overall rate be if all mental health and substance use disorders were accounted for?
2. Would that number be substantial enough to help change the commonly held belief that mental health issues affect only a small number of Canadians?
3. When someone is living with a mental health issue, who else might be affected by it?

What's in a Name?

helping professions all helping professionals (other than first responders) who work in the justice, health care, mental health, or social service sectors—for example, social workers, social service workers, counsellors, clergy members, human services workers, child and youth workers, employment counsellors, and others

The term "**helping professions**" is used often in this book. This term is used broadly to include any service provider, other than a first responder, who intervenes to help an individual, family, or community experiencing a mental health issue.

The helping professions include many jobs that assist those in need, including jobs that work directly with issues of poverty and food insecurity.

A helping profession could be that of child and youth worker, victim services worker, social worker, social service worker, counsellor, parole officer,

early childhood educator, court worker, or peer support worker, as well as many other positions in the justice, health care, mental health, and social service sectors. Because these professions involve interacting with people who regularly experience mental health difficulties, this book will be of benefit to all of them.

We see in practice that many helping professionals and first responders work together on multidisciplinary teams for the benefit of individuals and communities. It is not unusual in Canada for a police officer to work with a mental health professional or for a social worker at a child welfare agency to work hand in hand with an early childhood educator and a counsellor to address different aspects of an individual's mental health.

These collaborations can help to address difficult and layered issues in an individual's life and are the reality of work in the helping professions.

A variety of terms are used to identify a person with a mental health issue. Some professions use the term "patient." Others might use "client," "service user," "person in recovery," "person with lived experience," "participant," "consumer," or "survivor," among many others.

Terminology often changes in the helping professions. In this book—just like in the working world—you will be exposed to a variety of these terms. Working professionals and those wishing to work in the helping professions should understand the terms used in their field and use that set of terms while being aware that other terms may be used when collaborating.

For example, a police officer may report to the press that there was a "sexual assault victim" at a local park, who is now recovering in hospital. The hospital staff might call that same person a "patient." When that person is discharged and sees a psychotherapist for assessment, the term "client" could be used. After assessment, the person may be referred to a sexual assault centre for counselling, where the term "survivor" is used. This person may attend group therapy, where the term "participant" is used. Years later, if the person joins the board of an advocacy organization that focuses on improving the lives of those who have been assaulted, the term "person with lived experience" is applied.

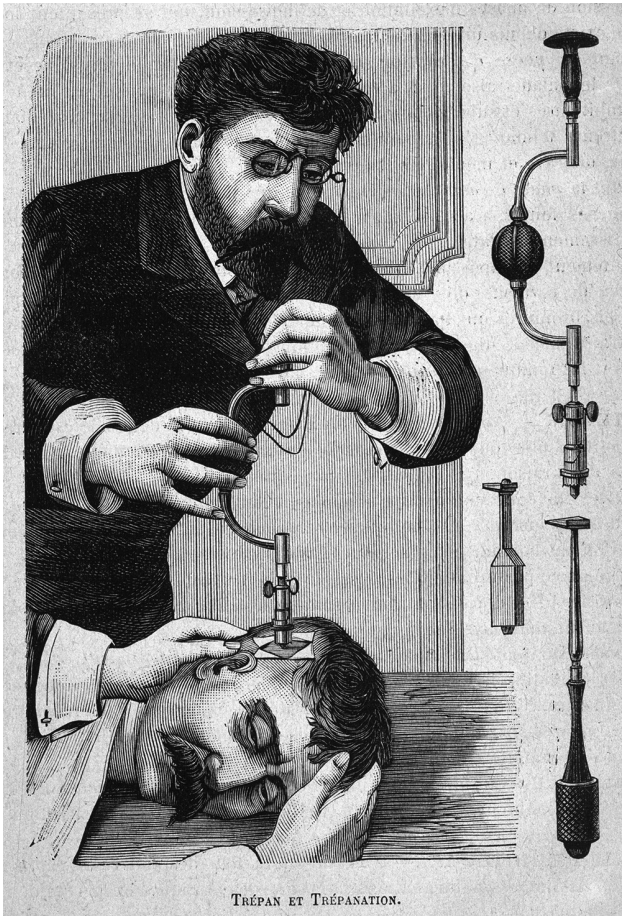
Now this person has had six identifiers applied to them. This might be seen as confusing; however, it is not unusual for those navigating through helping systems. There are many debates about identifiers. Is "patient" too passive? Is "consumer" too commercial? Is "victim" disempowering? Is "client" too general?

The reality is that the conversation about this is evolving and will be for some time. Furthermore, multiple professions all bring their own jargon,

institutionalization the practice of confining individuals or groups of people in residential institutions such as asylums, prisons, and mental health hospitals

context, and history to the work. If an individual has a particular preference regarding how they identify, it should be used. Whatever helps one better engage is paramount.

How Has Mental Health Been Treated Historically?



Trepanning was a surgical procedure used to treat mania and depression in the 18th century and earlier, in which a hole was bored into a patient's head and bone was removed.

While we have certainly come a long way recently, Western culture has had a variety of reactions to mental health. Some changes have been positive, resulting in an increase in understanding, supports, and dialogue.

However, it could be said that we have come a long way because we started out in such a deficit position around understanding mental health. As recently as the 18th century, a brutal surgical procedure known as trepanning, in which a hole was bored into a patient's head and bone was removed, was used to treat mania and depression (Gross, 2009, p. 122). It was thought that this procedure could cure madness by letting fumes and vapours out (p. 16).

Within our modern history, Canadians living with mental health were often forced into segregation from society and placed in asylums and institutions (Braslow, 1994; Panksepp, 2004). This practice of confining individuals or groups of people in residential institutions was known as **institutionalization**. Poor conditions and abuse were common, although the initial intent of the asylum movement was for more progressive, compassionate, and effective treatment of individuals (Sussman, 1998).

Dorothea Dix is credited with popularizing the asylum movement (Gollaher, 1993; Panksepp, 2004). She saw that the mentally ill were wrongly being sent to prisons and almshouses and thought that public care in institutions, hospitals, and asylums would be more effective and decent than what she observed in workhouses, prisons, almshouses, and even private homes (Gollaher, 1993). Almshouses were homes or communities built by charitable individuals or organizations to house the poor and others who could no longer work.

While addressing the Massachusetts legislature, Dix gave a well-researched and impassioned report on what she saw happening to people living with mental illness, who were held "in cages, closets, cellars, stalls, pens! Chained, naked, beaten with rods, and lashed into obedience" (Dix, 2006, p. 622).

Dix fought for treatment in humane hospitals as a moral alternative to the horrendous abuses she had witnessed (Ianacone, 1976). She toured North America and Europe speaking to the need to find compassionate alternatives, and the idea took root in Western culture (Greenstone, 1979).

Asylums were created as places where those living with mental health "could rest and receive personal care intended to restore their health," and there was hope that this would curb the "demonization and imprisonment" that many who suffered from mental illness faced (Government of Canada, 2006, p. 152).

From 1845 to 1914, asylums were opened in Canada, with the first of these institutions opening in Quebec (Sussman, 1998). That institution was called Beauport but was also known as the Quebec Lunatic Asylum. In 1855 it was estimated that 2,802 "lunatics" were "present within the borders of Canada" (Tuke, 1855, p. 328). The Toronto Asylum, which was built for 250 patients, was reportedly treating 400 individuals at that time, while Beauport was beyond its 150-patient limit. As an editorialist for *The Medical Chronicle* wrote in 1855, "The country wants these Institutions for the Insane—a common humanity demands them; and the country, for the sake of unfortunate humanity, must have them" (p. 329).

Canadians saw the creation of asylums as a way to humanely serve those with mental health while helping to remove them from poorhouses and prisons (Government of Canada, 2006).

While the theoretical reasoning behind this approach appeared sound and supportive, in actuality these asylums were too large, lacked individual

attention and effectiveness for patients, and ultimately served to "remove those with mental illness from the public sphere" (Government of Canada, 2006, p. 152). The institutions became overcrowded and treatment standards slipped (Greenland et al., 2001). While an exact total number of patients in Canada during the asylum era is difficult to come by because of lacklustre recordkeeping, some statistics exist to help shed light on the impact of asylums. From 1883 to 1937, the Toronto Hospital for the Insane reported 15,365 admissions, with 700 to 1,200 patients in the institution at any given time (Reaume, 1997, pp. 67–68).

Generally, people feared institutionalization in Canadian asylums "because of their unsanitary conditions and the fact that few people left them healed." These facilities "were seen as places where the most unfortunate went to die and thus were avoided by all except the very poor" (Miron, 2006, p. 23). Asylum physicians (also known as alienists) used drugs as "chemical restraints, not much better and sometimes worse than physical restraints, straitjackets and muffs that were also regarded as necessary evils" (Braslow, 1999, p. 6).

An example of a room in a mental health institution where, for the patient's safety, staff can supervise the patient's actions.

In the asylum era, patients were subjected to many indignities in the name of safety and control. Commonplace examples included being wrapped in warm or cold sheets and tied to a bed, being given continuous baths that could last for days, having electroconvulsive treatment (which is still used in a modified form today), sterilization, fever therapy (where patients were injected with a form of malaria), and lobotomies (Braslow, 1999). In the 1850s, a variety of scandals plagued the Canadian asylum system, from accusations of staff impregnating patients to reports that the bodies of the dead were being used inappropriately by medical professionals (Miron, 2006, p. 23). Many inmates reported sexual and physical abuse by inmates and staff. These accusations were often met with "denial or silence" by asylum officials (Reaume, 1997, p. 66).

Furthermore, asylum tourism was a popular activity in Canada (Miron, 2006, p. 19). This was a practice where members of the public were invited to tour asylums and mental institutions. These

tours were not limited to professionals looking to enhance their knowledge. It is estimated that in Canada alone, tens of thousands of casual observers participated (Miron, 2006, p. 19). In 1877, during a fall fair, the London Asylum reported 1,700 tourists on their grounds in only three days (Miron, 2006, p. 28).

Initially only a small group of professionals and experts associated with asylums in the 19th century wanted to see the practice of casual tourism end. Many experts of the day saw the practice as "progressive, advantageous, beneficial and even necessary" (Miron, 2006, p. 34).

Those working in asylums argued that giving the public access to the grounds and patients helped to raise awareness about mental health. However, it could also be argued that the practice treated people like oddities for entertainment (Miron, 2006, pp. 23, 28). It remains a grave example of the choices that those working on the front lines in the profession would make about vulnerable patients. Should we isolate individuals, or is exposure a good thing for societal understanding? What is the right balance between access and privacy? Does access like this remove **social stigma**? Are we helping to create an understanding or are we exploiting the pain of others?

social stigma
the association of shame, negativity, public disapproval, disgrace, and/or poor character unfairly associated with people who have a particular characteristic, such as those living with a mental health disorder

Perhaps present-day helping professionals will one day look back and wonder whether recent social media campaigns that encourage others to share their mental health issues were helpful. Will these efforts be perceived positively or negatively in the future?

DISCUSSION QUESTIONS

1. What might have been some positive outcomes of having tourists visit asylums?
2. What might have been detrimental about having tourists visit asylums?
3. What are some of the positive outcomes of mass media and social media campaigns that encourage people to talk about their mental health issues in public forums?
4. What are some of the potential negative consequences of mass media and social media campaigns for those living with mental illness?

The Deinstitutionalization Era

In the United States in 1955, over half a million Americans were patients in public mental health hospitals. This number began to decline in the mid-1950s,

when pharmaceuticals such as chlorpromazine, also known as Thorazine, and other **antipsychotic**, **antidepressant**, and **antianxiety medications** (Whitaker, 2005, p. 23) were beginning to be seen as more effective in treating mental illness than they had been in previous generations. Canada saw a similar patient population trend, with total mental hospital patients reaching a high of 59,308 in 1960 but dropping over 40 percent by 1971 to 34,183 (Kedward et al., 1974). The societal push to move away from confining people living with mental health issues in institutions and instead offering treatment in community settings was called **deinstitutionalization**. (See Chapter 3 for discussion of the effects of deinstitutionalization.)

antipsychotic medications
used to treat psychotic symptoms such as delusions, hallucinations, and mania; can also be used to treat severe depression and bipolar disorders; examples include Risperdal and Seroquel

antidepressant medications
prescription drugs used to treat depression and depressive symptoms by increasing the availability of neurotransmitters in the brain; examples include Cymbalta, Effexor, and Wellbutrin

antianxiety medications
used to treat anxiety disorders such as generalized anxiety disorder, social anxiety disorder, and panic attacks; examples include Ativan, Valium, and Xanax

deinstitutionalization
societal push to move away from confining people living with mental health issues in institutions and instead offering treatment in community settings

While these pharmacological therapies may have been seen at the time as a suitable replacement for asylum care, they "did not fundamentally replace the need for care and attention" (Dyck, 2011, p. 184). Other dimensions of care still required within community settings for those leaving institutions were not met. Once again, the societal response to mental illness was well-meaning reform but in execution was not all that was hoped for.

Many scholars and historians agree that the trend toward deinstitutionalization ran parallel to a few other developments in Western society. In 1952, certain medications used to combat mental health issues became more widely available. In the same year, the first mental health classification system was released, known as the *Diagnostic and Statistical Manual of Mental Disorders*. In 1957, the *Hospital Insurance and Diagnostic Services Act* was passed in Canada, moving funds to and prioritizing smaller clinics and local hospital wings for mental health services instead of large institutions. This ensured that no new large asylums would be built and that care would be moved to smaller health care centres over time. The assumption was made that by folding mental health services into the public health care system and community services, there would be a decrease in stigma (Dyck, 2011).

It is understandable why this assumption was made. If individuals needing help were afraid of being sent to institutions where there were allegations of mistreatment, it is reasonable to believe that many would hide their mental health concerns. Along with the stigma about mental health, there was also an earned reputation about asylums. Hospitals and other community settings were more attractive or more palatable to those living with mental health issues and to the broader public.

While there were serious problems inherent in institutional settings, there were notable problems with the newer health care system and community-based responses to mental illness.

Psychiatric issues were now being seen more often in family medicine and emergency rooms by professionals without specific expertise; services were no longer provided by a single service provider but instead by a "complicated matrix of services" (Dyck, 2011, p. 187) and multiple governmental departments, including the health care system; and housing and other **social services** were increasing the **red tape** involved in getting access to them. Scholars and those in the psychiatric profession suggested that the transition toward "the new face of mental health had been sorely underfunded, under-resourced and overpopulated" (Dyck, 2011, p. 187). While leaving an institutional setting was a good solution for some, others found themselves in communities that were underserviced and without proper housing, services, and employment.

social services
public services that provide benefits or assistance to those in need

red tape
excessive or complex paperwork, routines, and procedures that delay needed services

Many former asylum patients who had spent a great portion of their lives in institutions had lost the social, community, and family supports required for their successful transition back into society. Accessing services became a revolving door process for persons with chronic mental illness.

The revolving door syndrome also affected those who were never in the asylum era. **Revolving door syndrome** is the process in which a person goes through an ongoing cycle of discharge and readmission into hospitals, other mental health services facilities, or even prison (Voineskos, 1976).

revolving door syndrome
continued pattern of readmission into programs, services, or care due to relapse into mental illness

Research into hospitalization rates for mental health showed that readmission rates had increased substantially in Canada: in Ontario alone, the rate of readmission for patients with **psychotic disorders** increased from 25 percent in 1941 to 70 percent in 1971. For Ontarians with **non-psychotic disorders**, the rate of readmission went from 16 percent to 52 percent in the same 30-year time frame. According to the research, the figures for all of Canada were, on the whole, comparable (Martin et al., 1976). This meant that many received acute care when longer-term care was required, which led to the exacerbation of mental health issues and more pressure on patients and their loved ones.

psychotic disorders
mental health disorders that can include hallucinations, deluded thinking, and abnormal perceptions

non-psychotic disorders
mood, anxiety, and other disorders that do not co-occur with psychotic symptoms

Well-regarded mental health historian Gerald Grob (1997) has theorized that multiple factors were at play in creating mental health's deinstitutionalization era, including but not limited to the following:

- psychiatrists beginning to seek and create opportunities in private practice for themselves, which represented a large reorganization of the profession;
- shifting views about the treatment of those living with mental illness, including public awareness about the conditions that

people were forced to live in within institutionalized settings; from this, the outcry to ramp up legal and political challenges to the system gained momentum;
- the creation and use of new prescription medications to treat mild, moderate, and severe mental health issues; these were starting to be seen as an effective part of treatment in ways they had not been previously; and
- growing government involvement in North American mental health research and the creation of public health programs to deal with mental health and **social welfare**; these were seen as more appropriate uses of taxpayer dollars than funding large institutions that were developing bad reputations.

social welfare
provision of assistance to disadvantaged groups or individuals that is organized through government or private social services

A *Canadian Journal of Psychiatry* report by Sealy and Whitehead in 2004 suggested that "deinstitutionalization" was perhaps not the best term to describe what was happening to those who were leaving large institutions. Instead, this report used the term **transinstitutionalization** to describe the process by which those living with severe mental health issues were now simply being reinstitutionalized into other, mostly smaller, institutions such as private and public group residences, nursing homes, emergency rooms, and various parts of the criminal justice system.

transinstitutionalization
reinstitutionalizing people with mental health issues into prisons, group homes, and other residential programs

Individuals living with mental health issues might find themselves living after deinstitutionalization/transinstitutionalization in places that include the following:

- **Group homes:** Smaller residential settings with trained staff who are available 24 hours a day to provide special care to those in difficult social situations or who have mental illness or behavioural disorders. These homes are often located in residential neighbourhoods.
- **Nursing homes:** Residential facilities that are equipped to house and care for the elderly or people with chronic illnesses. Trained workers include medical staff who are available 24 hours a day.
- **Hospitals:** Health care institutions for the treatment of acute health issues or injuries.
- **Penitentiaries/prisons:** Facilities established for the confinement of those who have committed crimes or are awaiting trial.
- **Shelters for the homeless:** Temporary residences for those who live on the streets. These facilities are usually open for only part of the day.

group homes
smaller residential setting for those living with mental health issues; trained staff available 24 hours a day for persons who require special care due to difficult social situations, mental illness, or behavioural disorders; often located in residential neighbourhoods

nursing homes
residential facilities equipped to house and care for the elderly or people with chronic illness; trained staff, including medical staff, are available 24 hours a day

hospitals
health care institutions for treatment of acute health issues or injury

penitentiaries/prisons
facilities established for the confinement of persons who have committed crimes or are awaiting trial

shelters for the homeless
service that provides temporary residence for individuals who are living on the streets

VOICES FROM THE FIELD

Was Deinstitutionalization Really Such a Bad Thing?

By Dorothy Cotton, PhD, CPsych, Psychologist

There is a tendency to swear gently under one's breath whenever the word "deinstitutionalization" is mentioned. Deinstitutionalization is widely held to be responsible for many of the evils of the world—homelessness, the increasing incarceration of people with mental illnesses, increased demands on police time, the black plague, holes in the ozone layer, racism, listeria, and so on.

No one, including me, would disagree that there is a very real problem of increasing interactions between police and people with mental illness—but is deinstitutionalization really the culprit?

Deinstitutionalization actually began a very long time ago—back in the 1950s. The initial driving force behind the movement was not so much political, or based on some idealistic philosophy, as it was driven by the fact that new treatments had been developed—pharmacological treatments to be precise. People who were previously untreatable and unstable became treatable and able to function outside of institutions.

Housing issues are part of a larger set of issues that can have a dire effect on the ability to get the help that is needed to become or stay healthy. See Chapter 9 for more on housing and mental health.

(*Continued on next page.*)

VOICES FROM THE FIELD

This chapter feature exposes you to the opinions and practices of those working in the helping fields. In these features we seek to introduce readers to a variety of opinions from a variety of helping professionals. These are intended to be taken as opportunities to engage in discussion. You may or may not agree with the opinions expressed, but we hope you will approach the material with an open yet critical eye. Use these features as an opportunity to engage in discussion about the topics and opinions presented throughout the book.

However, treatment was not the only factor contributing to deinstitutionalization. Human rights came into play as well. Somewhere along the line, it occurred to policy-makers that people with mental illnesses were entitled to the same kinds of rights and liberties that other Canadians enjoyed. The path here was not dissimilar from the path followed by women, various ethnic and minority groups, people with physical disabilities, and/or people of varying sexual orientations. All of these groups at some point in our not-so-distant history were arbitrarily denied their rights because they were different—and as we all know, it is a short leap from "different" to "bad and scary" or even "deficient and lesser."

We seem to have largely gotten over that as far as most of these groups are concerned. But in regard to people with mental illnesses—well, we are not there yet.

Is the reason that police spend so much time with people with mental illnesses an indication that we need more psychiatric hospital beds? I will concede this is an empirical question, and it is not outside the realm of possibility that a *few* more beds might make a difference. But I remain unconvinced that it would make a large difference. The vast majority of people who have mental illnesses and interact with police would not ever get admitted to hospital even if there were beds. And if they don't need hospital beds, then what do they need?

- **They need access to services.** But services and hospital beds are not the same thing. No one would argue that you need to be admitted to hospital for a broken leg or an ear infection. Ditto for the vast majority of mental illnesses.
- **They need tolerance from the public.** How many interactions between police and a person with a mental illness are initiated by some panicked member of the public who has made the very common—and erroneous—link between "mental illness" and "dangerous."
- **They need understanding and realistic assessment from police.** How many interactions between police and people with mental illness go south because the officer has started with the assumption that mental illness equals danger? I often point out that the very same people that police feel threatened by are dealt with on a daily basis by unarmed nurses and psychologists and other mental health professionals. We deal with it without use of force. It *can* be done.
- **They need housing.** Early data from the Mental Health Commission's *At Home* study, which provides housing to people who were homeless and ineligible for most housing,

indicate that when people have housing, their interactions with the police decrease. Hardly a surprising correlation.

- **They need jobs.** You don't have to review a whole lot of research to know that unemployed people get into less trouble than employed people. Sure, it's a bit of a vicious circle—employers are reluctant to hire people with mental illnesses. Research suggests that employers would rather hire someone with a criminal record than with a history of mental illness. Employers have a whole lot more trouble reintegrating people with mental health problems back into the workplace after a period of illness than they do with people with physical illness. Think of your own workplace and how people with mental health problems are treated—both when they are at work and when they are away. It's a common refrain from people with mental health problems that when they are off sick with the flu or heart disease, people are lined up at their door with casseroles and good wishes. When you are off for depression? Not so much.

Are interactions with people with mental illness an increasing burden for police services? Obviously. Should the police be the front line of the mental health system? Probably not.

What can you do? You start from where you have some power and control—and maybe that is internally. Work on attitudes and stigma in your own organization. And then work on all the other *real* causal factors where you can: agitate for housing, for community services, for educating the public, for more research dollars for mental health, for better employment strategies.

Deinstitutionalization? It's not really the main culprit.

Source: Cotton, 2014.

Discussion Questions

1. The author states that many calls concerning people with mental illness are initiated by "some panicked member of the public." What other specific sources (people or organizations) might contact the police for assistance with a mental health concern?
2. The author compares police officers with nurses and psychologists. Is this a fair comparison? In what ways is the role of law enforcement different from these other professions?
3. What arguments can be made for and against the statement the author makes about police using force? Why is this topic controversial?

The Diagnostic and Statistical Manual of Mental Disorders

***Diagnostic and Statistical Manual of Mental Disorders* (DSM)**
the standard North American text for classifying and diagnosing mental disorders

In the 20th century, efforts to classify and diagnose mental disorders became formalized with the creation of a standard North American text, the ***Diagnostic and Statistical Manual of Mental Disorders* (DSM)**.

In the 19th century, blanket terms such as "idiocy" or "insanity" were used to describe mental illness (Torrey & Miller, 2001, p. 336) (see Figure 1.2). Over time efforts were made to further categorize mental illness. In response to variability in diagnosis and confusion by mental health clinicians, a group that would later become known as the American Psychological Association recommended a uniform classification system for mental disorders (Sanders, 2011).

Though its roots can be traced back to the 1918 *Statistical Manual for the Use of Institutions for the Insane* (Figure 1.2), the first edition of the DSM as we know it today was published in 1952 and listed 106 disorders. The latest edition, published in 2013 (DSM–5, the fifth edition), has 152 disorder classifications (McCarron, 2013).

substance abuse
pattern of recurring and harmful substance use (e.g., alcohol and/or drugs) that disrupts normal life functions, including the ability to function normally in school, at home, or in the workplace; substance use in situations that present physical hazards, such as driving or operating machinery; and continued use of substances despite social or interpersonal costs

substance dependence
can include an increased tolerance to alcohol and drugs, symptoms of withdrawal when not using, increased consumption, multiple unsuccessful efforts to end use, and so on; occurs when a person adapts or builds a tolerance to repeated exposure to or ingestion of a substance; stopping regular usage causes symptoms of withdrawal

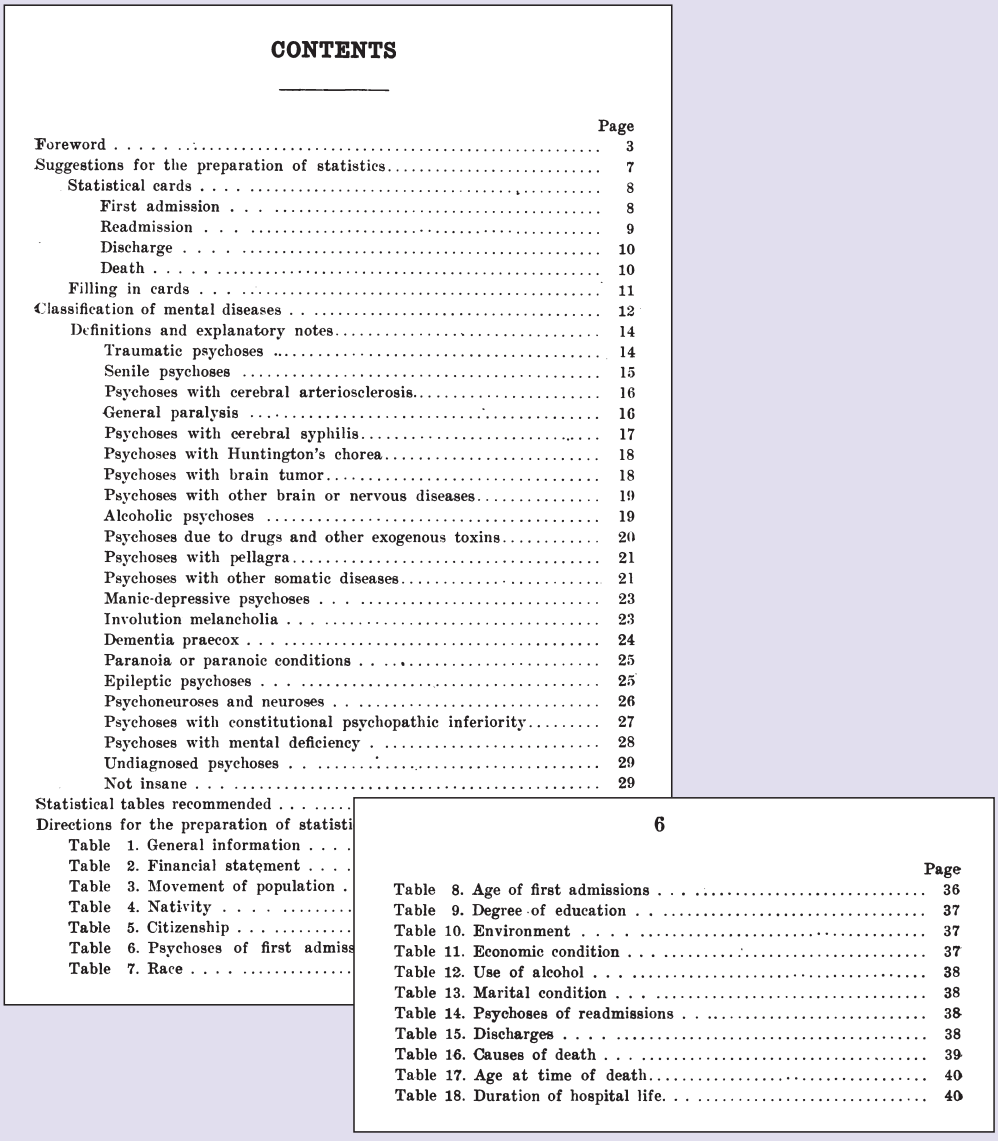
In some ways the updating is fairly straightforward and lacks controversy. Categories have been folded into one another as a way of simplifying them or updating language. For example, in the latest edition the separate diagnoses of **substance abuse** and **substance dependence** were replaced by the common term "substance use disorder."

bereavement
normal period of mourning or sadness after the loss of someone or something

Other changes are more controversial, such as the removal of the **bereavement** exclusion for diagnosing major depressive disorder. When a person loses a loved one, it can be argued that it is very normal to grieve. The bereavement exclusion meant that clinicians wouldn't treat the normal grieving process as an illness, which could lead to more people being medicated when a better fit for treatment might be time, reflection, or talk therapy. Another change was a reduction in the criteria required to diagnose attention deficit disorder. Some believe that the number of diagnoses for a variety of mental health issues are already inflated and that a lower number of criteria for diagnosis will cause a rise in misguided pharmaceutical interventions, and pharmaceuticals can have side effects (Wakefield, 2016).

Asperger's syndrome was removed from the latest DSM; it became part of the broader autism spectrum disorder. The change with regard to Asperger's syndrome is particularly interesting because it speaks to the power and problem of diagnosis.

FIGURE 1.2 A Little Piece of Mental Health History: Table of Contents from the 1918 *Statistical Manual for the Use of Institutions for the Insane*



CONTENTS

6

The 1918 manual was the precursor of the DSM. The DSM has become the standard text in the modern era for diagnosing and classifying mental health. Note the 22 original mental health classifications found in the 1918 manual.

For some people, having a diagnosis can be helpful because it provides some clarity about why individuals and families are experiencing certain issues. Also, a diagnosis can be a practical aid to provide access to appropriate services. In-person and online support communities can also be found for a specific diagnosis, and they provide comfort and a place to explore what others have done to help them cope or thrive.

When a diagnosis is changed or taken away, it is possible to lose access to support programs that have been relied on. A person may no longer qualify for certain social services, including income, housing, and medical supports. The person may also feel as though a part of their identity has been taken away.

On the other hand, a diagnosis can be incorrect. It can take an individual down a path of institutionalization or into improper and unhelpful medical or psychiatric treatment, which can result in grave consequences. A diagnosis can also be stigmatizing, making a person feel as though they are different from others and defined by a term they have only recently become aware of.

Homosexuality was wrongly considered a psychiatric disorder according to the DSM until it was declassified in 1973. At the time, LGBTQI2+ people who were already dealing with a lot of stigma and societal pressure about their sexuality were also told they had a diagnosable illness that required the intervention of mental health professionals; there were psychological theories that homosexuality was a defect and was caused by "hormonal exposure, excessive mothering, inadequate or hostile fathering, sexual abuse, etc." (Drescher, 2015, p. 566).

Being told you are either ill or immoral when you are neither is problematic, and the diagnosis added to stigma. Even among mental health professionals who were LGBTQI2+, there was a "realistic fear of adverse professional consequences for coming out at the time" (Drescher, 2015, p. 570).

The problem with diagnoses such as these is that they not only add to stigma but create real-world problems for large groups of well people who are wrongly classified as unwell.

Similar critiques about the DSM have persisted in regard to issues around understanding and accommodating for diversity, culture, and the impacts of societal and structural racism. The latest version of the DSM has made some attempts to incorporate cultural concepts into the manual, but these attempts have had some pushback and scrutiny that "DSM-disorders themselves are not subjected to the cultural critique" and that it is guilty of "expression[s] of ethnocentrism and of stereotyping certain groups" (Bredström, 2019, p. 357).

Beyond the relevant critiques, other concerns are inherent in the diagnosis of any mental health disorder. Dr. Robert McCarron, who works as an internist-psychiatrist, succinctly describes how difficult it is to diagnose and treat mental illnesses in contrast to physical diseases (2013, p. 360):

> The practice of medicine is an imperfect science, with the constant struggle of diagnostic and therapeutic uncertainty. This applies to the complex and dynamic field of psychiatry. Although recent advances help us to better understand, categorize, and treat psychiatric disorders (such as depression, bipolar disorder, anxiety, and substance misuse), there is more work to be done. It is easier to reliably diagnose and treat disorders when a specific cause is known. For example, most urinary tract infections can be quickly diagnosed and treated. Blood glucose levels can be reliably quantified. Most bone fractures can be accurately diagnosed by observing objective clinical features and radiologic findings. It is much more challenging to diagnose and treat disabling conditions that lack objective data, such as dysfunctional and maladaptive behavioral disorders.

Mental health straddles several professional lines and touches more people than we realize. For example, families, loved ones, colleagues, and many others can exist within the orbit of a person who is living with a mental health issue. In addition to the personal dimension, an affected individual might interact with medical professionals, the justice system, social services, and other front-line workers across the multidisciplinary landscape. These interactions can be positive or negative and can have a strong impact either way, and this is why it has never been more important for professionals across the spectrum to incorporate understanding about mental health into their work.

The next chapter will show how mental health and the various helping professions have intersected recently, but we cannot study current trends without understanding the basic historical concepts that were shared in this chapter. Studying the past helps us to avoid repeating mistakes so that we can move forward and help others more effectively. This work will continue to adapt and evolve, just as practitioners in the helping professions will adapt and evolve to better meet the needs of individuals and communities.

POINTS TO REMEMBER

- ✓ Mental health issues are common over the course of life and are emerging as core issues for those in the helping professions whose work is related to justice, health care, and social services. This work takes place across professions in multidisciplinary teams in communities across Canada.
- ✓ Current ways of working with mental health issues are in many respects a vast improvement over the era of institutionalization. While begun with good intentions, the mass institutionalization of those living with mental health issues led to stigmatization, generally poor treatment outcomes, and deterioration of the civil rights of many individuals.
- ✓ While categorizing and diagnosing mental health problems can help those who are afflicted, to researchers and those helping on the front lines, a mental health diagnosis is not all that defines someone. No matter which helping profession we are in, we must continue to strive to treat people as complex individuals who are worthy of dignity and respect while continuing to improve our knowledge of mental health issues and the best practices for treatment within our communities.

KEY TERMS

antianxiety medications, 16
antidepressant medications, 16
antipsychotic medications, 16
bereavement, 22
deinstitutionalization, 16
Diagnostic and Statistical Manual of Mental Disorders (DSM), 22
first responders, 6
group homes, 18
helping professions, 10
hospitals, 18
institutionalization, 12
justice system, 6
multidisciplinary team, 6
non-psychotic disorders, 17
nursing homes, 18
penitentiaries/prisons, 18
psychotic break, 3
psychotic disorders, 17
red tape, 17
revolving door syndrome, 17
shelters for the homeless, 18
social services, 17
social stigma, 15
social welfare, 18
substance abuse, 22
substance dependence, 22
transinstitutionalization, 18

FURTHER READING AND RESOURCES

Canadian Mental Health Association. (n.d.). *History of mental health reform*. https://ontario.cmha.ca/provincial-policy/health-systems-transformation/history-of-mental-health-reform

Kastner, J. (Director). (2014). *Out of mind, out of sight* [Film; documentary]. National Film Board. https://www.nfb.ca/film/out_of_mind_out_of_sight

Ontario Ministry of Children, Community and Social Services. (n.d.). *The reasons for institutions*. https://www.mcss.gov.on.ca/en/dshistory/reasons/index.aspx

Patton, R. (Director). (1977). *Mental patients' association* [Film; documentary]. National Film Board. https://www.nfb.ca/film/mental_patients_association

Sussman, S. (2017). The history of mental health services in Canada. *Madridge Journal of Internal and Emergency Medicine*, *1*(1), 7–13. https://doi.org/10.18689/mjiem-1000103

REFERENCES

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

Braslow, J. (1999). Insights: Where biopsychiatry came from: A short history of somatic therapies from 1900 to the 1950s. *The Harvard Mental Health Letter/from Harvard Medical School*, *16*(2), 5–7.

Braslow, J.T. (1994). Punishment or therapy: Patients, doctors, and somatic remedies in the early twentieth century. *Psychiatric Clinics of North America*, *17*(3), 493–513.

Bredström, A. (2019). Culture and context in mental health diagnosing: Scrutinizing the DSM-5 revision. *Journal of Medical Humanities, 40*, 347–363. https://doi.org/10.1007/s10912-017-9501-1

Cotton, D. (2014, Winter). Was deinstitutionalization really such a bad thing? *Canadian Police Chief Magazine*, 11–12.

Dix, D. (2006). "I tell what I have seen": The reports of asylum reformer Dorothea Dix. *American Journal of Public Health*, *96*(4), 622–624.

Drescher, J. (2015). Out of DSM: Depathologizing homosexuality. *Behavioral Sciences*, *5*(4), 565–575.

Dyck, E. (2011). Dismantling the asylum and charting new pathways into the community: Mental health care in twentieth century Canada. *Histoire sociale/Social history*, *44*(2), 181–196.

Gollaher, D.L. (1993). Dorothea Dix and the English origins of the American asylum movement. *Canadian Review of American Studies*, *23*(3), 149–176.

Government of Canada. (2006). *The human face of mental health and mental illness in Canada, 2006*. Minister of Public Works and Government Services Canada. Catalogue no. HP5-19/2006E. http://www.phac-aspc.gc.ca/publicat/human-humain06/pdf/human_face_e.pdf

Greenland, C., Griffin, J.D., & Hoffman, B.F. (2001). Psychiatry in Canada from 1951 to 2001. In Q. Rae-Grant (Ed.), *Psychiatry in Canada: 50 years, 1951–2001* (pp. 1–16). Canadian Psychiatric Association.

Greenstone, J.D. (1979). Dorothea Dix and Jane Addams: From transcendentalism to pragmatism in American social reform. *The Social Service Review*, *53*(4), 527–559.

Grob, G.N. (1997). Deinstitutionalization: The illusion of policy. *Journal of Policy History*, *9*(1), 48–73.

Gross, C.G. (2009). *A hole in the head: More tales in the history of neuroscience*. MIT Press.

Hospital Insurance and Diagnostic Services Act, 1957 [replaced by the *Canada Health Act*, RSC 1985, c C-6].

Ianacone, B.P. (1976). Historical overview: From charity to rights. *Temple Law Quarterly*, *50*, 953.

Kaiser, H.A. (2008). Mental health and Canadian society: Historical perspectives. *Health Law Review*, *16*(3), 79.

Kedward, H.B., Eastwood, M.R., Allodi, F., & Duckworth, G.S. (1974). The evaluation of chronic psychiatric care. *Canadian Medical Association Journal*, *110*(5), 519.

Martin, B.A., Kedward, H.B., & Eastwood, M.R. (1976). Hospitalization for mental illness: Evaluation of admission trends from 1941 to 1971. *Canadian Medical Association Journal*, *115*(4), 322.

McCarron, R.M. (2013). The DSM-5 and the art of medicine: Certainly uncertain. *Annals of Internal Medicine*, *159*(5), 360–361.

Miron, J. (2006). "Open to the public": Touring Ontario asylums in the nineteenth century. In J.E. Moran & D. Wright (Eds.), *Mental health and Canadian society: Historical perspectives* (pp. 19–48). McGill-Queen's University Press.

Panksepp, J. (2004). Biological psychiatry sketched—Past, present, and future. In J. Panksepp (Ed.), *Textbook of biological psychiatry* (pp. 3–32). Wiley-Liss.

Pearson, C., Janz, T., & Ali, J. (2013). Mental and substance use disorders in Canada. Statistics Canada Catalogue no. 82-624-X. https://www.statcan.gc.ca/pub/82-624-x/2013001/article/11855-eng.htm

Reaume, G. (1997). Accounts of abuse of patients at the Toronto Hospital for the Insane, 1883–1937. *Canadian Bulletin of Medical History/Bulletin canadien d'histoire de la médecine*, *14*(1), 65–106.

Sanders, J.L. (2011). A distinct language and a historic pendulum: The evolution of the *Diagnostic and Statistical Manual of Mental Disorders*. *Archives of Psychiatric Nursing*, *25*(6), 394–403.

Sealy, P., & Whitehead, P.C. (2004). Forty years of deinstitutionalization of psychiatric services in Canada: An empirical assessment. *Canadian Journal of Psychiatry*, *49*(4), 249–257.

Statistics Canada. (2012). Canadian community health survey: Mental health. Statistics Canada Catalogue no. 82-624-X. https://www.statcan.gc.ca/pub/82-624-x/2013001/article/tbl/tbl1-eng.htm

Statistics Canada. (2019, June 25). Mental health characteristics: Perceived need for mental health care. Table 13-10-0619-01. https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1310061901

Statistics Canada. (2020, November 26). Deaths, by cause, Chapter V: Mental and behavioural disorders (F00 to F99). Table 13-10-0143-01. https://doi.org/10.25318/1310014301-eng

Sussman, S. (1998). The first asylums in Canada: A response to neglectful community care and current trends. *Canadian Journal of Psychiatry*, *43*(3), 260–264.

Torrey, E.F., & Miller, J. (2001). *The invisible plague: The rise of mental illness from 1750 to the present*. Rutgers University Press.

Tuke, D.H. (1855). The insane in Canada. *The Medical Chronicle*, 326–329.

Voineskos, G. (1976). Part-time hospitalization programs: The neglected field of community psychiatry. *Canadian Medical Association Journal*, *114*(4), 320.

Wakefield, J.C. (2016). Diagnostic issues and controversies in DSM-5: Return of the false positives problem. *Annual Review of Clinical Psychology*, *12*, 105–132.

Whitaker, R. (2005). Anatomy of an epidemic: Psychiatric drugs and the astonishing rise of mental illness in America. *Ethical Human Sciences and Services*, *7*(1), 23–35.