



World Network of Users and Survivors of Psychiatry

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A Discussion Paper on Policy Issues at the Intersection of the Mental Health System and the Prison System

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1. Debunking the Myth: Prevalence of Psychosocial Disability in Prison - What Does It Mean?

It has become a commonplace of mental health advocates and criminal justice advocates, often without lived experience of incarceration in either system, to point to high numbers of people with mental health problems¹ in prison, and argue for increasing transfer of direct control and supervision of such individuals to the mental health system.

We contest the implied assumption that the presence of people with mental health problems in prison is inherently shocking or problematic, as well as the recommendation of greater involvement of the medical-psychiatric system in social control as a response to this situation.

Given the traumatic backgrounds of people who end up in prison and the relationship of trauma to mental health problems, the prevalence of mental health problems by any measures should not be surprising. Trauma may be common among prisoners for reasons including discrimination in access to justice, discrimination in the definition of crime and in the establishment of penalties for different crimes, as well as factors influencing the commission of criminal acts.

The gathering of information on mental health problems, whether by self-reporting or diagnosis, may change over time for reasons unrelated to people's experience of distress. Diagnostic trends in particular change with the fluctuation

¹ We have used various terms in this paper reflecting diverse ways that our community talks about our experiences. Please see the WNUSP paper "Psychosocial Disability" explaining the meaning of this term as a preferred terminology. It is available at <http://www.chrusp.org/home/flyers>.

of DSM/ ICD categories, and with the attention placed on mental health issues by authorities.

Given the traumatizing nature of prison - deprivation of freedom, toxic environment, bad food, strip searches, etc. - people inevitably experience distress and altered consciousness that can be labeled as mental health problems. The traumatizing nature of prison can be encapsulated in the degrading entry procedure, described from experience of a U.S. prison:

"Walking into a system where you are being given a number that becomes your identification. A barber shaves your head, they have you strip your clothes off and de-lice you, dropping this powder. There are 50 men in this line. It has a humiliating, degrading, punishing effect immediately. How trauma-insensitive that is, the anxiety that drives through your body is incredible. It reminded me of the concentration camps. They say that Germany was so bad but we're doing the same thing. They call it rehabilitation - they break you and rebuild you."

The number of people labeled with mental health problems in prison is sometimes compared with declining numbers in psychiatric institutions, as if to argue that the psychiatric system by failing to confine people with psychosocial disabilities is creating the conditions for these individuals to commit crimes and be incarcerated in the prison system. It is a tautology that incarceration of any demographic would stop those individuals from committing crimes. Human rights principles do not permit profiling and preventive detention based on psychosocial disability, any more than they would permit profiling and preventive detention based on race, gender or age. To the extent that the mental health system has been placed in the role of public safety official, with legal duties to confine individuals based on risk assessment of any kind, this is incompatible with the duty to serve the individual client and must be removed in order that the mental health profession may be able to comply with its human rights obligations. Moreover, mental health treatment is far from being foolproof, reliable or safe. Expansion of mental health treatment, even when community-based, has not resulted in decrease of mental health problems, but rather in an upsurge, iatrogenic problems in both physical health and mental health, and enforced dependency on mental health providers for services that maintain individuals in poverty and segregation.

2. Mental Health System is Coerced Compliance - Not a True Alternative to Prison

A. Diversion into Coerced Medical Disablement is Not a Viable Alternative to Incarceration

Diversion from the court system to coerced mental health treatment is also proceeding apace. "Mental health courts" in the U.S., although participation in them is voluntary at the outset, induct individuals into coerced compliance with treatment, in exchange for suspension of prison sentence. A guilty plea is required, and compliance with treatment is supervised by the court, with the possibility of a prison/jail sentence being imposed if compliance is not deemed adequate.

In Japan, a preventive detention law for people with mental disabilities went into effect in 2005. Under this law, a person accused of a crime and deemed by the court to have a mental disability can be diverted from a trial of their guilt or innocence, to a hearing before a mental health tribunal to determine whether civil commitment should be imposed. This means that a person labeled with mental disability is denied the right to be considered innocent until proven guilty, and unlike all other criminal suspects can have detention imposed without proof of having committed the crime. Unlike the U.S. mental health courts, this diversion is not voluntary but is decided by the court.

The use of diversion schemes has been promoted as an alternative to the punitive sentences imposed by the "criminal justice" system, however we cannot consider it in any way an acceptable alternative, particularly when there are penalties for noncompliance with the prescribed treatment. Mental health treatment appears to many people to be beneficial to all concerned, to society as well as to the person accused of crime. But when the mental health system is made to do the duty of public safety official, it promotes neither public safety nor mental health. Irreparable harm is done by the coerced ingestion of mind-numbing drugs (the main modality of forced treatment), and by the narrative of incapability that removes a person from responsibility for, and confidence in, making deliberate choices to shape his/her own life.

Proponents of restorative justice, and of any theory of justice that supports re-integration, need to consider the implications of the social model of disability for their work, and to go deeper in imagining systems of accountability that respect human dignity. Coerced mental health treatment of people accused or convicted of crime is not restorative, and it does not contribute to meaningful re-integration. It is furthermore a form of discriminatory violence that fits the criteria for torture and ill-treatment.

B. Double Discrimination Against People with Psychosocial Disabilities in Prison

People with psychosocial disabilities in prison experience double discrimination. In some U.S. jurisdictions a person who has been given a psychiatric diagnosis is not eligible for programs with early leave such as work release and military style

or modeled shock camps - 6 months of military style discipline and training after which the remainder is served on parole. (This blatant discrimination extends also to people with physical disabilities, for example if a person is unable to run with their legs.) Men and women with psychiatric diagnoses who have physical illnesses such as cancer or diabetes are often not treated for the physical illness which is explained as a psychiatric symptom.

In addition, state systems have access to past records. Due to having received a psychiatric label/diagnosis in the past, upon entry into the prison/penal system, a person can be placed in solitary confinement until being "seen" or evaluated by a mental health professional. This takes place in a segregated part of the prison, not the general population.

Forced drugging and confinement in a psychiatric unit within a prison can be similar to the way it's done in psychiatric institutions, but double discrimination emphasizes a person's status as being under the control of others.

"I felt, here I am a prisoner and mental patient. Those two things together left me with no liberty. I felt if I was captured by one, I could escape. Why would a judge listen to me not to medicate me, here I am a prisoner found guilty by judge and jury, there's no way I'm going to win a medication hearing or a retention hearing. The hearing was very short, about a minute. The psychiatrist said, "You need to take this," and that was it, bye, they send you back.

"There's no access to a lawyer in the penal system for psychiatric things. No access to a phone. The culture inside prison is often controlled by gang activity, underground crime. There are a lot less phones in the psychiatric piece than in regular prison - 120 prisoners inside the psych hospital in prison, and two phones. You can't get to the phone. And you have to be in programs all day.

"In the hospital they call you by name and not a number. You think you're a person again in the psych ward and not in prison. My thing was, you're getting out of one cage to be in another. This one's shinier, more buttons... but that doesn't make it not a cage."

3. Accountability

A. Insanity Defense is Counter-Productive

Behind the schemes to divert people from courts and prisons into the mental health system lies a belief that people with psychosocial disabilities do not belong

in a penal system, but instead need medical treatment in order to not re-offend. The traditional penal system objectives of retribution and deterrence are seen as inapplicable to people with psychosocial disabilities, who are considered uniquely unable to control their actions. The remaining objectives of incapacitation and rehabilitation (primarily in the form of compulsory medication and other incapacitating treatments) are intensified.

This is seen most clearly in the operation of the insanity defense and its equivalents in every legal system. This defense - that a person is not guilty, or cannot have responsibility imputed for a crime, because of his/her mental state at the time the crime was committed - is considered a pillar of our legal systems and a sacred right of defendants. At some times and in some places, where the objectives of retribution and deterrence were primary, it may have operated to allow people to avoid punishment that was seen as unfair given the circumstances.

However, ordinarily a verdict of insanity results in psychiatric rather than penal incarceration (and the Standard Minimum Rules on the Treatment of Prisoners so provide, in Rule 82). Whether it is labeled as punishment or treatment, the deprivation of liberty, lack of privacy, having one's daily life controlled by authorities, assaults on personal dignity and integrity from strip searches to forced medication have substantially similar effects on people in both institutions. Both institutions promote a negative self-image and submitting to authorities rather than seeking internal self-justification and conscience.

There is, furthermore, an overlap between the two systems that discloses their underlying unity. Despite the label of "treatment," the mental health system administers a wide range of punitive measures. These include "steps" or "levels" of increasing control, "privileges", and the imposition of coercive regimes in response to "failure to comply with prescribed treatment". Rehabilitation in prison, when imposed coercively, is substantially similar to forced mental health treatment (e.g. programs like "DARK", psychological intervention, coercion to attend self-help groups, and programs to "correct the personality").

The CRPD takes an opposite approach to responsibility of persons with disabilities for their own actions. Article 12, Equal Recognition Before the Law, provides that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life. Legal capacity implies both rights and responsibilities, and "all aspects of life" can encompass criminal as well as civil matters. As the Office of the High Commissioner for Human Rights has said, this requires abolition of the insanity defense and its replacement by disability-neutral concepts such as the subjective element of a crime (*mens rea*).

B. Community Responsibility and Support

Article 12 also provides that States Parties must provide access to the support needed by persons with disabilities in exercising their legal capacity. The Committee on the Rights of Persons with Disabilities has clarified that support "respects the autonomy, will and preferences of the person," and that States Parties must replace all substituted decision-making schemes with support.

What might support look like in relation to crime and punishment?

It could start with community members taking responsibility to help avoid the commission of a crime and defuse conflict situations. Two examples:

"I was in the Apple Store and saw a kid bend down and took some hardware or software for iPad, he ripped open the box and put it in his sleeve. I had two choices - I could tell the staff, assumed he was going to steal, maybe he was testing the staff. I said to him, 'What you got there?' He put it back and didn't take it."

"One gentleman was camped out in his parents' backyard. The county mental health director called me [as head of a peer advocacy center], didn't want to call police, didn't want to go through routine, asked if we would go over. The guy didn't want respite, didn't want any government thing. He didn't get locked up that I know of, and moved off his parents' porch."

These examples might also be understood in a restorative justice framework, and there is a great deal of congruency between the values of restorative justice and the social model of disability as enunciated in the CRPD. Both promote inter-subjective and relational processes for arriving at decisions, respect for individual dignity and the equality of persons, autonomy, and reliance on community members rather than the state. Both encourage personal accountability and responsibility as a manifestation of mutual respect. Both encourage a holistic and big picture approach to justice, which is simultaneously grounded in lived experience: what do participants need, what is lacking (or over-present) in our social and economic system that impacts on the current situation, what is crime and what should be criminalized?

The prison reform and abolition movement, particularly including current and former prisoners, have a significant role to play in developing guidance and policy and in sharing their experience and wisdom with the community. Prisoners with psychosocial disabilities especially need to be consulted. This is a part of "re-integration" that is often overlooked.

The CRPD framework, restorative approaches to justice, and prison reform/abolition need to inform each other so as to transform our communities to promote social and individual healing, self-determination and mutual respect and accountability, for all people including people with disabilities. We need to reject one-sided approaches that either fail to address disability, or that address it from a medical model rather than social model perspective leading to increased discrimination. We need to fundamentally change both the legal framework for civil and criminal responsibility, and the relationship of responsibility to the law itself. We need to simultaneously build the capabilities of communities and ensure that the law reflects and enforces values of fairness, equality, freedom from torture and de-escalation of violence. The scope of the task should not overwhelm us, but inspire us to begin.

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Intentional Peer Support, www.mentalhealthpeers.com.

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