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Review Paper

'Old' and 'new' institutions for persons with mental illness: Treatment, punishment or preventive confinement?

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Summary Despite countless promises for a better life by national commissions, governments and the international community, there has evolved a vicious cycle of neglect, abandonment, indignity, cruel and inhuman treatment, and punishment of persons with mental illness. This shameful history of benign, and sometimes malignant, neglect of persons with mental illness is well understood, with the deep stigma and unredressed discrimination, the deplorable living conditions, and the physical and social barriers preventing their integration and full participation in society.

The maltreatment of this vulnerable population has been reinforced by the hurtful stereotypes of incompetency and dangerousness. The belief that persons with mental illness are uniformly dangerous is an equally harmful myth. It provides policy makers with an ostensible justification to exercise control over persons with mental illness, even if they have not committed a violent offence. However, research demonstrates that the class of persons with most mental illnesses is no more dangerous than other populations, and that the vast majority of violence is committed by persons without mental illness.

This article will show how this vulnerable population has been unconscionably treated. First, the gross violations of human rights that have occurred, and continue to occur, in 'old' psychiatric institutions will be examined. The deinstitutionalization movement, however, resulted in new places of confinement for this population, such as jails, prisons and homeless shelters. The second part of this paper will explore the new realities of criminal confinement of persons with mental illness. As we will see, incarceration of this vulnerable population in the criminal justice system has caused enormous suffering. If Dostoyevsky was correct that the

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'degree of civilization… can be judged by entering its prisons', then by that measure, we are a deeply uncivilized society.

In 1972, I covertly entered a brutal, inhuman institution for the criminally insane in Eastern North Carolina as a pseudo-patient under a US Department of Justice study. What I experienced during those many weeks would shape how I view what Irving Goffman called 'total institutions'. Since that formative experience as a young law student, I have closely observed institutions that warehouse persons with mental illness in many regions of the world, ranging from the Americas and Europe to the Indian subcontinent and Asia. Those experiences, together with the careful study of human rights reports and judicial decisions, have led me to one simple conclusion. Despite countless promises for a better life by national commissions, governments and the international community, there has evolved a vicious cycle of neglect, abandonment, indignity, cruel and inhuman treatment, and punishment of persons with mental illness.[62] This is not true in every place, time and circumstance. There are pockets of deep caring and compassion. However, for the vast majority and in most geographic regions, this sad fact remains a tragic reality.

The shameful history of benign, and sometimes malignant, neglect of persons with mental illness is well understood, with the deep stigma and unredressed discrimination, the deplorable living conditions, and the physical and social barriers preventing their integration and full participation in society.[1] The maltreatment of this vulnerable population has been reinforced by the hurtful stereotypes of incompetency and dangerousness.

A person's competency is their most valuable attribute. If the public perceives, or if a court determines, that a person is incompetent, it robs them of all dignity; the right to control the most fundamental aspects of life such as bodily integrity and personal or financial affairs. Society forgets that most persons with mental illness are competent to make decisions about their lives. They may lack competency to perform certain tasks at particular times, but rarely are they generally incompetent, as often assumed in law and practice.

The belief that persons with mental illness are uniformly dangerous is an equally harmful myth. It provides policy makers with an ostensible justification to exercise control over persons with mental illness, even if they have not committed a violent offence. However, research demonstrates that the class of persons with most mental illnesses is no more dangerous than other populations, and that the vast majority of violence is committed by persons without mental illness.[2]

There is no better illustration of these hurtful stereotypes than in the English Mental Health, which was guided by the slogan, 'sound, safe and secure'.[3] The UK Government has allowed a few, high-visibility cases of dangerous behaviour to create an act that is based more on preventive confinement than on treatment or patients' rights. Historians will look back and observe that the new Mental Health Act increased the stigma of mental illness, reinforced hurtful stereotypes, deemphasized the role of treatment as the primary justification for social action, and widened the net of compulsion in the community. It is for this reason that the World Health Organization (WHO) uses the UK Act as a paradigm of what not to do in mental health law reform.[4]

This paper will show how this vulnerable population has been unconscionably treated. First, the gross human rights violations that have occurred, and continue to occur, in 'old' psychiatric institutions will be examined. During the mid-to-late 20th Century, however, many of these old institutions were closed as part of a social compact with mentally ill persons and their families to provide community care. The deinstitutionalization movement, however, resulted in new places of confinement for this population, such as jails, prisons and homeless shelters. The second part of this paper will explore the new realities of criminal confinement of persons with mental illness. As we will see, incarceration of this vulnerable population in the criminal justice system has caused enormous suffering. If Dostoyevsky was correct that the 'degree of civilization … can be judged by entering its prisons', then by that measure, we are a deeply uncivilized society.

Psychiatric hospitals: the continuing legacy of neglect and abuse

Persons with mental illness seek four inter-related human rights: freedom from unwarranted detention (liberty); humane living conditions (dignity);

amelioration of stigma and discrimination (equality); and access to high-quality mental health services (entitlement).[5] These principles are enshrined in international law in treaties and declarations that apply directly to the rights of persons with mental illness. In 1991, the United Nations (UN) adopted Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (MI Principles).[6] The MI Principles include: a preference for community care; the right to the least restrictive environment; clear standards and natural justice for compulsory admission; legal representation; and the right to information.

In 2006, the UN adopted the Convention on the Rights of Persons with Disabilities, which specifically include persons with mental impairments, 'which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others (Article 1)'. Article 15 prohibits torture or cruel, inhuman or degrading treatment or punishment; Article 22 protects the right to privacy and health information; Article 25 grants equal access to the highest attainable standard of care, without discrimination; and Article 29 guarantees the equal right to participate in political life.[7]

Finally, WHO's current project on the human rights of persons with mental disabilities has multiple themes that correspond with the human rights principles suggested in this article: the right to the highest attainable standard of mental health care; freedom from physical, sexual and mental abuse and other forms of inhuman and degrading treatment; the right to liberty, autonomy and security of the person; the right to equality, dignity and respect; and the right to be free from discrimination in the exercise of their political, civil, religious, social and cultural rights.[8]

Human rights jurisprudence, principally in Europe and now emerging in the Americas, focuses on the four themes of liberty, dignity, equality and entitlement through cases involving involuntary detention, conditions of confinement, civil rights and mental health services.[9]

Liberty: involuntary confinement

Article 5 of the European Convention on Human Rights guarantees the right to liberty and security of the person. *Winterwerp v. The Netherlands*[10] established that civil commitment must follow a 'procedure prescribed by law' and cannot be arbitrary; the person must have a recognized mental illness, and require confinement for the purposes of treatment: 'Except in emergency cases, the individual concerned should not be deprived of his liberty unless he has been reliably shown to be of ''unsound mind.'' The very nature of what has to be established before the competent national authority — that is a true mental disorder — calls for objective medical expertise.'

X v. the United Kingdom, a case I brought while Legal Director of MIND (National Association for Mental Health), mandated speedy periodic review by a court with the essential elements of due process. Habeas corpus was insufficient for these purposes because it simply reviewed the technical lawfulness of the detention, but not the substantive justification.[11]

The European Court of Human Rights (ECHR) has been highly active in addressing the human rights of persons with mental illness under Article 5, requiring a recognized mental illness and a speedy independent hearing by a court for involuntary admission to hospital. But what if a person is 'voluntarily' admitted, but in fact has not given consent? The problem of 'non-protesting' patients arises when persons are confined in fact but not under the force of law. A person may succumb to a show of authority[12] or may be unable to provide consent. In *R.V. Bournewood Community and Mental Health NHS Trust, ex parte L*, the House of Lords ruled that an informal patient incapable of giving consent was not 'detained' and, if he were, there was common law power to restrain and detain a mentally incapacitated person in his best interests.[13] In *HL v. United Kingdom*, however, the European Court held that Article 5(1)(e) had been breached in *Bournewood*: 'The right to liberty in a democratic society is too important for a person to lose the benefit of Convention protection simply because they have given themselves up to detention, especially when they are not capable of consenting to, or disagreeing with, the proposed action.'[14]

Dignity: conditions of confinement

Non-governmental organizations continue to find appalling conditions in institutions and residential homes for persons with mental illness.[15] These include long periods of isolation in filthy, closed spaces; lack of care and medical treatment such as failure to provide nursing, mental health services and essential medicines; and severe maltreatment such as being beaten, tied-up, and denied basic nutrition and clothing. The ECHR said that vigilance is vital due to 'the position of powerlessness which is typical of patients confined in psychiatric hospitals'.[16] Despite this vigilance,

the ECHR's early jurisprudence was highly deferential to medical opinion in cases involving inhuman and degrading treatment.[17]

In *Herczegfalvy v. Austria*, a patient was unnecessarily and involuntarily sedated and tied to a hospital bed for several weeks. The Court found no violation of Article 3 of the Convention because it was 'therapeutically necessary',[18] but how could such maltreatment be either therapeutic or necessary?

Two cases which I brought while at MIND illustrate the deferential approach of the European Commission of Human Rights in the 1980s. In *A. v. United Kingdom*, the European Commission found no violation of Article 3. A patient in Broadmoor was kept in a ward with beds positioned inches apart, with no safety or security, and he had not seen a doctor for nearly 10 years.[19] In *B. v. United Kingdom*, I was asked by the Commission to visit a man in Broadmoor who had been placed in isolation. He had been in a tiny cell for 5 weeks. I was told that he was extremely dangerous. However, when I entered the cell, he was sitting naked, huddled in a corner. The smell of the room was so putrid, caked with excrement and soaked in urine, that I was overpowered and had to leave. The patient had only been allowed out for 20 minutes per day. The Commission forced a 'friendly settlement', under which the patient was paid a paltry sum.

More recently, the Court has required increased medical attention[20] and appropriate facilities for[21] persons with mental illness. More importantly, it has emphasized that the European Convention's proscription of inhuman and degrading treatment includes actions designed to humiliate persons with mental illness.[21]

A new generation of impassioned advocates is bringing cases to the Inter-American Commission on Human Rights (IACHR) with promising results.[22] In *Victor Rosario Congo v. Ecuador*, the IACHR found a violation of the right to humane treatment.[23] A person with mental illness had been struck in the head, denied medical treatment, and left in his cell for 40 days. The case is important because the IACHR relied on the UN Principles for the Protection of Persons with Mental Illness: 'inhuman and degrading treatment or punishment should be interpreted so as to extend the widest possible protection against abuses, whether physical or mental'.[6] The Commission asserted that 'a violation of the right to physical integrity is even more serious in the case of a person held in preventive detention, suffering a mental disease, and therefore in the custody of the State in a particularly vulnerable position'.[24]

The IACHR rules allow 'precautionary measures' to be taken 'in serious and urgent cases … to prevent irreparable harm to persons.' [25] In December 2003, for the first time in its history, the IACHR approved 'precautionary measures' to protect the lives, liberty and personal security of 460 persons detained in a psychiatric institution in Paraguay. Two boys, who are the focus of the case, have been in isolation for more than 4 years, naked and without access to bathrooms. 'The cells are completely bare. Holes in the cell floors that should function as latrines are caked over with excrement. Each boy spends approximately 4 hours of every other day in an outdoor pen, which is littered with human excrement, garbage and broken glass.'[26] The precautionary measures adopted by the IACHR require Paraguay to protect the lives and physical and mental safety of the 460 persons detained in the institution, as well as to comply with international protocols on the use of isolation. By using 'precautionary measures', advocates can avoid the burdensome and time-consuming process of 'exhausting domestic remedies' before gaining access to the IACHR. The 'precautionary measures' procedure, therefore, promises to help redress the countless cases of maltreatment and abuse of persons with mental illness in the Americas.

The maltreatment of persons with mental illness is an international problem, well beyond Europe and the Americas.[27] During an investigation of Japanese mental hospitals, I found abysmal conditions. [28] In one hospital, a patient had been secluded for some 30 years. The conditions in which he lived were so restricted that he lost the use of his legs. Adjacent to his cell was a large cavern in the floor where dozens of patients were placed and bathed at the same time. Yet, in India, I found that many of the hospitals were not crowded and the conditions were amiable.

What was the reason for the differences between Japan and India? In Japan, mental illness was a matter of shame, and families would shun those with supposed abnormalities. However, in India, the culture was to care for mentally ill persons within their families and communities. It is clear that cultural acceptance of mental illness as part of the human condition is a powerful predictor of how well people will be treated and integrated into society.

Equality: civil rights

Human rights norms extend to the exercise of a wide array of civil rights both within and outside institutions. Simply because a person has

a mental illness, or is subject to confinement, does not mean that he or she is incapable of exercising the rights of citizenship. Human rights bodies have helped to secure equality through norms of access to the courts and privacy. The ECHR has found violations of the right to a fair and public hearing in the determination of a person's civil rights. The subject matter of these cases includes the right to control property,[10] to exercise parental rights,[29] and to be granted a hearing in the determination of incompetency[30] or placement into guardianship.[31]

The right to a 'private and family life' under the European Convention can be a powerful tool to safeguard the civil rights of persons with mental illness. The ECHR, for example, has applied this privacy protection to free correspondence,[32] informational privacy,[33] marriage[34] and the parent–child relationship.[35] It has, thus far, declined to do so for sexual freedoms, but advocates are pursuing cases to defend this form of intimacy.

Entitlement: right to mental health services

The final human rights theme (entitlement) is more fragile than the others, involving the right of access to core mental health services. Although essential health services have a basis in ethics, they are more difficult to attain under international law. The right to health is a social and economic entitlement. Notably, the European Convention of Human Rights does not capture this set of entitlements. In addition, the IACHR has not pursued the right to health, even though the Protocol of San Salvador enunciates a full set of health rights.[36] Consequently, the scope and definition of the right to mental health has remained vague and variable.

Several contemporary initiatives on health rights in general and mental health rights in particular are promising. The UN Committee on Economic, Social and Cultural Rights issued General Comment 14 on the Right to Health.[37] The UN Commission on Human Rights subsequently appointed a Special Rapporteur with a mandate to focus on the right to health.[38] The Rapporteur's first report in 2003 identified three primary objectives: promote the right to health as a fundamental human right; clarify its contours; and identify good practices for operationalizing the right.[39] The Rapporteur subsequently published a report on the right to health for persons with mental illness, which offers a comprehensive account of the elements to adequate mental health services.[40]

WHO has a project focusing on mental health and human rights.[41] As part of that project, WHO published a mental health legislation manual that provides a tool for countries to adopt international human rights norms into domestic legislation.[4] One key norm is the provision of 'public mental health', which frames the right to mental health in terms of population-based services. Thus, countries would be responsible for offering screening for mental illnesses, mental health education and psychiatric services in hospitals and the community. International human rights norms will only have maximum impact if they are adopted by nations into domestic laws, policies and programmes.

The transmigration from 'old' to 'new' institutions: the moral outrage of the mentally ill in prison

During the mid-20th Century, health services for seriously mentally ill individuals were almost exclusively provided in large, often Victorian, institutions. Since that time, there has been wide recognition that psychiatric institutions are unacceptable places to care for and treat persons with mental illness, being prohibitively costly, isolating and neglectful, and sometimes abusive and punitive. Civil rights advocates in the 1960s, in an unlikely alliance with fiscal conservatives, fought to close these institutions. These activists believed that persons with mental illness have rights and should be integrated in the community. They reformed mental health laws to establish more rigorous standards and procedures for compulsory admission, and litigated to close antiquated institutions. Around the same time, fiscal conservatives felt that psychiatric institutions were too expensive. For example, Ronald Reagan, then Governor of California, began the dismantling of state mental hospitals.

Known as deinstitutionalization, the unequivocal promise made to persons with mental illness and their families was that the state would erect a social safety net in the community, including supportive housing and mental health services. That promise was never kept, and was possibly fraudulent at inception. Community mental health services were chronically underfunded, fragmented and often punitive.[42] At the same time, the public clamoured to remove the mentally ill from their neighbourhoods; a call that resonated well with 'law and order' politicians. These public feelings were inflamed by press reports of violence by a minute percentage of persons with mental illness, as well as by the spectre of homeless persons on their streets.[43]

What eventually transpired was a massive transmigration of mentally ill persons from 'old' to 'new' institutions, such as jails, remand centres, prisons, nursing homes and homeless shelters.[44]

Many persons with mental illness were simply left destitute on the streets. We pass them every day in urban areas as we avert our eyes and step over or around them. The vast majority of mentally ill persons languishing in the streets or the correctional system are poor and often racial or ethnic minorities. The correctional system has become the mental health system of last resort, as this population has been segregated and forgotten. Incarceration and homelessness have become part of life for society's most vulnerable population.

It did not have to be that way. There are good data to show that mental institutions can close in ways that are beneficial to patients if there is adequate discharge planning and community services.[45] What is needed is the political will to provide a range of supportive and psychiatric services in the community. But that never happened for the vast majority of persons with mental illness.

Incarceration of the mentally ill

The data on incarceration of persons with mental illness are not fully collected in many parts of the world, and there are surely differences among the various countries and regions. Nevertheless, the data that do exist paint a picture of vast numbers of seriously mentally ill persons in the correctional system. Prevalence rates for all forms of mental illness in the prison population are markedly higher than rates in the community.[46] In many different countries, severe mental illness occurs five to 10 times more frequently among persons in prison than in the general population.[47] These data hold true in countries as diverse as Australia,[48] Iran,[49] New Zealand,[50] the UK[51] and the USA.[52]

Mentally ill prisoners, moreover, are highly vulnerable. This population is twice as likely to have been homeless before entering prison.[53] They suffer disproportionately from comorbidities with drug and alcohol abuse.[54] While in prison, few inmates receive access to adequate mental health services — both psychological care and essential medicines. Mentally ill prisoners are at very high risk of harm or death.[55] Many experience physical or sexual abuse and are injured before and during their time in confinement. One study found that mentally ill prisoners were 17 times more likely than the general population to die within 2 weeks following release.[56]

Prisons as toxic, non-therapeutic environments

Most of the mentally ill who are incarcerated begin in jails or remand centres pending trial. There is usually no professional screening for mental illness and few methods of diversion from the criminal justice system. Some are so actively psychotic (e.g. schizophrenic or manic depressive) that any layperson would notice — hearing voices, talking to God, withdrawn, incoherent mumbling, dissociation from social life, playing with excrement and self-mutilation. Others have a variety of clinical symptoms that require professional mental health treatment. These men and women then find themselves in prisons that are overwhelmed by numbers and the impossibility of providing humane, effective mental health services in punitive institutions. In many prison systems, only a small fraction of the mentally ill have access to mental health treatment — poor diagnosis, lack of timely access, over-belief that prisoners are 'just faking', oversedation as a form of behaviour control and inadequate control of side effects [e.g. tardive dyskinsia (uncontrollable shaking), obesity and diabetes, heat reactions].[53] At best, many prison systems offer crisis management for the mentally ill.

Even if prisons could offer decent mental health services, they are counter-therapeutic, toxic environments.[57] Mentally ill inmates, at the extreme, may have little appreciation of why or how they were imprisoned. They may have serious difficulties in cognition, emotion, interpersonal skills and impulse control. Mentally ill prisoners are often subjects of derision, abuse and violence by other inmates and correctional staff. They are unable to fend off sexual and other violent assaults. More importantly, prison philosophy is infused with keeping rules and discipline, and severely punishing those who fail to comply or simply are disruptive. Consequently, mentally ill prisoners find themselves in segregated, high-security settings or, worse, in seclusion. Their conditions of confinement can be much worse than even in the general prison population. They are unable to cope with the loneliness, harshness and pain inflicted in these settings. They deteriorate mentally, repeatedly break rules, re-enter isolation and have their sentences extended; an endless, vicious cycle of inhuman and degrading treatment.[58]

Inhuman and degrading treatment in the correctional system

Human rights activists that so deplored the conditions of 'old' psychiatric hospitals, and fought so hard for their closure, would be dismayed to observe the same types of abusive conditions in prisons. Just as human rights bodies found that mental hospital conditions violated international law, so too have they made the same findings in prisons.

In some cases, the European Court has been as timid as it was in the early mental hospital cases. For example, in *Kudla v. Poland*, the Court found no violation of Article 3, despite the fact that an inmate received no mental health services during 3 years of pre-trial detention: 'The Court has consistently stressed that the suffering and humiliation involved must in any event go beyond that inevitable element of suffering or humiliation connected with a given form of legitimate treatment or punishment' (Para. 92). But how is the absence of services for a person with mental illness legitimate, and why should the mentally ill be punished for years even before a trial?[59]

However, in other cases, the Court has condemned harsh prison conditions. It has found a violation of Article 3 in cases where prisoners were segregated and had their sentences extended to threaten a mentally ill inmate's 'physical and moral resistance', which was 'not compatible with the standard of treatment required in respect of a mental ill person' (Para. 115). Similarly, it has criticized abhorrent conditions in detention centres, including overcrowded and dirty cells with insufficient sanitary and sleeping facilities, insufficient hot water, no fresh air or daylight, and no exercise facilities. Although there was no deliberate ill treatment, the conditions were so awful that they violated Article 3. In a direct repudiation of its earlier statements regarding mental hospitals, the Court found that an Article 3 violation could be found if the cumulative effects of the conditions were sufficiently abhorrent.[60]

Even the conditions in psychiatric wings of prisons have been found to be inhuman and degrading. In *Peers v. Greece*, the Court found an Article 3 violation when prisoners were detained in very small cells, the toilets were not screened, there was inadequate ventilation and it was extremely hot. Although there was no intention to humiliate or debase the prisoners, the conditions in which they lived caused feelings of anguish and inferiority capable of humiliating and debasing them.[61]

Promises made and breached: from neglect to abuse and punishment

Governments and civil society, in all parts of the world, have treated persons with mental illness horribly in old and new institutions. Countless promises have been made to right the wrongs, but these promises were dishonoured in practice. Instead of a future of compassion, care and integration in the community, the mentally ill have experienced a perpetual cycle of coercion and maltreatment. Perhaps it is time to see this issue not so much as a social problem, but as a human rights imperative, adopting the principles of liberty, dignity, equality and entitlement.[5]

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