

**EXPLORING THE CIRCLE: MENTAL ILLNESS, HOMELESSNESS  
AND THE CRIMINAL JUSTICE SYSTEM IN CANADA**

**Tim Riordan**  
Political and Social Affairs Division

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## **EXPLORING THE CIRCLE: MENTAL ILLNESS, HOMELESSNESS AND THE CRIMINAL JUSTICE SYSTEM IN CANADA**

### **INTRODUCTION**

It is not uncommon for studies to examine mental illness or homelessness or the criminal justice system. However, less attention has been paid to the extent to which these issues are interconnected. Through an exploration of current Canadian research, this paper seeks to highlight the ways in which each of these phenomena is tied to the others.

### **DEFINITION AND PREVALENCE OF MENTAL ILLNESS AMONGST THE GENERAL POPULATION**

Mental illness and mental disorder are hard to define. The Canadian Psychiatric Association describes mental illness as “clinically significant patterns of behavioural or emotional functioning that are associated with some level of distress, suffering ... or impairment in one or more areas of functioning (e.g., school, work, social and family interactions).”<sup>(1)</sup>

These concepts are also hard to measure, a fact highlighted by Health Canada in *A Report on Mental Illnesses in Canada*.<sup>(2)</sup> In 2002, the Canadian Community Health Survey found that 2.6 million Canadians (approximately 1 in 10) reported symptoms of mental illness.<sup>(3)</sup>

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- (1) Canadian Psychiatric Association, *Youth and Mental Illness*, on-line: <http://www.cpa-apc.org/MIAW/pamphlets/Youth.asp> (date accessed: 5 April 2004).
  - (2) Health Canada, *A Report on Mental Illnesses in Canada*, Ottawa, 2002, p. 17, on-line: [http://www.cmha.ca/english/research/r\\_mic/full\\_report\\_mic.pdf](http://www.cmha.ca/english/research/r_mic/full_report_mic.pdf) (date accessed: 5 April 2004).
  - (3) Statistics Canada, “Canadian Community Health Survey: Mental health and well being,” *The Daily*, 3 September 2003, on-line: <http://www.statcan.ca/Daily/English/030903/d030903a.htm> (date accessed: 5 April 2004).

## PREVALENCE OF MENTAL ILLNESS AMONGST FEDERAL INMATES

### A. Mental Health Survey

In 1988, the Correctional Service of Canada (CSC) undertook a national study of mental illness among offenders held in federal institutions. This Mental Health Survey was designed to measure the nature, prevalence and severity of mental illness, and resulted in changes to research practices within CSC.<sup>(4)</sup> More precisely, the Offender Intake Assessment process was altered to permit CSC to track changes in mental illness prevalence rates over time.

In 2002, CSC published the results of its examination of changes in mental illness prevalence rates amongst federal inmates over a four-year period. Between 1997 and 2001, the number of new offender admissions into federal custody declined by 4.3%.<sup>(5)</sup> However, the overall proportion of in-custody offenders who had been struggling with mental illness at the time of their admission increased sharply.

In 1997, approximately 8 per 100 of the total in-custody offender population had been diagnosed with a mental illness at the time of their admission. By 2001, this proportion had increased by 24% to approximately 10 per 100. During this same period, the total number of in-custody offenders who had been taking prescription medication to treat mental illness at the time of their admission increased by 50%, from approximately 11 per 100 to 16 per 100.

In 1997, only 2 per 100 of the total in-custody offender population had been hospitalized due to mental illness at the time of their admission. By 2001, this proportion had increased by 15% to 2.3 per 100. During the same period, the total number who had been receiving outpatient services immediately prior to their admission increased by 20%, from 5.5 per 100 to approximately 7 per 100.

Further findings of the CSC survey, including data on offenders' mental health status prior to their admission on their latest sentence, are provided below:

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(4) Roger Boe and Ben Vuong, "Mental health trends among federal inmates," *FORUM on Corrections Research*, Vol. 14, No. 2, May 2002, p. 1.

(5) *Ibid.*

**Table 1**

<b>Percentage of Total Offender Population With a Diagnosis of Mental Illness on Admission<sup>(6)</sup></b>					
<b>Calendar year</b>	<b>1997</b>	<b>1998</b>	<b>1999</b>	<b>2000</b>	<b>2001</b>
Diagnosed current	7.8	8.3	8.9	9.3	9.7
Diagnosed past	11.4	12.3	13.1	14.0	14.7
Prescribed medication current	10.7	11.7	13.3	14.4	16.1
Prescribed medication past	23.3	25.0	27.3	29.6	31.7
Hospitalized current	2.0	2.3	2.4	2.4	2.3
Hospitalized past	17.4	17.9	18.4	19.1	19.8
Outpatient current	5.5	5.4	5.9	6.2	6.6
Outpatient past	17.6	18.0	18.5	21.2	21.9

## **B. The Health Care Needs Assessment of Federal Inmates**

The findings of the Mental Health Survey allow for an examination of changes over time in mental illness prevalence rates amongst in-custody offenders in the federal corrections system, something that is absent from many Canadian studies. In other respects, however, the results are limited. Fortunately, more comprehensive data are available from newer sources, including Brent Moloughney's "A Health Care Needs Assessment of Federal Inmates in Canada."<sup>(7)</sup> Care should be taken when comparing the results of studies, as key concepts may be defined, measured and reported differently.

### **1. Mental Health Issues at Intake**

Studies conducted in the United States, the United Kingdom, and New Zealand show that mental disorders are more prevalent in prison inmates compared to the general population. The results of Moloughney's recent study of offenders in the federal corrections system in Canada are consistent with this pattern. Details of the proportion of male inmates with mental health-related concerns at intake are provided below:

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(6) *Ibid.*, p. 3.

(7) Brent Moloughney, "A Health Care Needs Assessment of Federal Inmates in Canada," *Canadian Journal of Public Health*, Vol. 95, Supp. 1, March/April 2004.

**Table 2**

<b>Proportion of Male Inmates With Mental Health-related Concerns at Intake, 2002<sup>(8)</sup></b>			
<b>Age</b>	<b>&lt;50 years</b>	<b>50-64 years</b>	<b>65+ years</b>
Alcohol abuse	46.4%	25.7%	21.6%
Drug abuse	54.4%	16.2%	5.3%
Appears mentally disordered	2.6%	3.2%	3.2%
Emotional/mental health requiring immediate attention	6.9%	5.9%	4.8%
Reporting emotional/mental health problem	14.6%	13.7%	12.0%
Recent mental health intervention/hospitalization	14.2%	11.1%	10.5%
Shows signs of depression	9.7%	7.4%	10.5%
Previous suicide attempt(s)	14.5%	9.3%	9.5%
May be suicidal	5.0%	3.6%	3.2%

Moloughney identified key differences amongst the federal inmate population.<sup>(9)</sup> For example, he found that a much higher proportion of women (31%) reported emotional or mental health problems than men (15%), information that was consistent with that already available. There were also differences based on age, with younger inmates having higher rates of alcohol and drug abuse than older inmates, and ethnicity, with both male and female Aboriginal offenders having higher rates of alcohol abuse than non-Aboriginal offenders.

## **2. Suicide Rates**

Suicide is 3.7 times more prevalent amongst offenders than the general population.<sup>(10)</sup> In CSC institutions, it is the second leading cause of death after natural causes.<sup>(11)</sup> Moloughney found that while the differences between offenders who commit suicide and offenders as a whole are small, offenders who commit suicide are more likely to be younger, non-Aboriginal, single, serving a life or indeterminate sentence, and held in maximum security. Further, his analysis of completed suicides found that 46% had self-injured in the past, 61% had made previous suicide attempts, and most had psychiatric diagnoses or symptoms.

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(8) *Ibid.*, p. S38.

(9) *Ibid.*, pp. S37, S39-40, and S43.

(10) *Ibid.*, p. S46.

(11) *Ibid.*

## PREVALENCE OF MENTAL ILLNESS AMONGST THE HOMELESS POPULATION

### A. Measuring Homelessness and the Personal Characteristics of Homeless Persons

Measuring the prevalence of homelessness and the personal characteristics of homeless persons presents significant challenges.<sup>(12)</sup> In *Structural and Systemic Factors Contributing to Homelessness in Canada*, Laura Buckland *et al.* commented, “due to the lack of good data, most researchers have been understandably reluctant to provide estimates of the total number of Canadians experiencing homelessness.”<sup>(13)</sup>

The authors of this study found that certain groups of homeless persons, such as those who do not use shelters or who live in very temporary accommodation, have been excluded from traditional counts that most often focus on persons living in shelters. Moreover, it was suggested that studies involving a count of the homeless living in shelters, if improperly designed, are “more likely to overstate the role and incidence of various personal characteristics, including serious mental illness and substance abuse issues, and may simultaneously underestimate the impact of broader social structural factors such as deep low income.”<sup>(14)</sup>

### B. The Pathways Project

The Pathways Project was undertaken to assist in filling this research gap. Data collected over an 18-month period were intended to “estimate the prevalence of mental illness among people who are homeless”<sup>(15)</sup> in the City of Toronto. Conscious of criticisms of earlier studies focusing on shelter users, the authors first undertook a preliminary survey of participants of drop-in and food programs. Having found that 93% of homeless persons were shelter or hostel users, it was determined that a focus on this population could be justified. Further

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(12) For a more detailed discussion of these challenges, refer to Patricia Begin *et al.*, *Homelessness*, PRB 99-1E, Parliamentary Research Branch, Library of Parliament, Ottawa, 8 January 1999, pp. 10-16.

(13) Laura Buckland *et al.*, *Structural and Systemic Factors Contributing to Homelessness in Canada: An Analysis of Research Gaps and Proposed Research Directions*, Canadian Council on Social Development, Ottawa, 23 March 2001, p. 6.

(14) *Ibid.*, p. 5.

(15) Mental Health Policy Research Group, *Mental illness and pathways into homelessness: proceedings and recommendations*, Toronto, 1998, on-line:  
[http://www.camh.net/hsrcu/html\\_documents/pathways\\_proceedings.html](http://www.camh.net/hsrcu/html_documents/pathways_proceedings.html) (date accessed: 7 April 2004).



safeguards, including categorizing the study sample by degree of shelter use, and interviewing subjects who consistently avoided shelters, sought to ensure that results would be representative of the wider homeless population.

Findings were presented in early 1998. The researchers emphasized lifetime prevalence rates as they felt this measure was more significant. Key conclusions included the following:

- Approximately 66% of homeless persons have a lifetime diagnosis of mental illness. This is 2-3 times the rate in the general population.
- Approximately 66% of homeless persons have a lifetime diagnosis of substance (i.e., drug and/or alcohol) abuse. This is 4-5 times the rate in the general population.
- Approximately 86% of homeless persons have a lifetime diagnosis of either mental illness or substance abuse. This is 2.7 times the rate in the general population.
- Almost every homeless person with a lifetime diagnosis of mental illness also had a diagnosis of substance abuse.
- No difference in rates of mental illness was found amongst shelter users and shelter avoiders.
- Contrary to popular perception, only 5.7% of homeless persons had a diagnosis of psychotic disorder (e.g., schizophrenia).
- 21.4% of homeless persons cited either substance abuse (17.7%) or mental illness (3.7%) as the reason for becoming homeless for the first time.
- In the year immediately prior to their homelessness, 6% of homeless persons had been in a psychiatric facility, 20% had received services for substance abuse problems, 25% had received psychiatric outpatient services, and 30% had spent time in police stations or jails.

In his review of homelessness and health, Stephen Hwang identified consistent patterns in the prevalence of mental illness and substance abuse amongst homeless people. Drawing on studies in Canada and the United States, including the Pathways Project, he emphasized the high rate of alcohol abuse and concurring disorders (i.e., a diagnosis of both mental illness and substance abuse). Hwang also found evidence supporting the claim of the low prevalence of psychotic disorders in homeless people.<sup>(16)</sup> Others, including Brendan O’Flaherty, have taken a different view, arguing that “overall, the contribution of drug use to homelessness is very likely to be modest to marginal.”<sup>(17)</sup>

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(16) Stephen W. Hwang, “Homelessness and health,” *Canadian Medical Association Journal*, Vol. 164, Issue 2, January 2001, p. 231.

(17) Begin *et al.* (1999), p. 45.

## MENTAL ILLNESS, HOMELESSNESS AND THE CRIMINAL JUSTICE SYSTEM

### A. Health System Challenges – Deinstitutionalization and Funding for Community Health

There continues to be debate over whether homelessness is a “pathway” to mental illness and substance abuse, or mental illness and substance abuse are “pathways” to homelessness. Regardless of one’s position in this matter, research completed by the Mental Health Policy Research Group, Hwang, and Zapf, Roesch and Hart<sup>(18)</sup> suggests that mental illness and substance abuse are more prevalent amongst homeless persons.

Historically, individuals with mental illness were institutionalized in psychiatric or other long-term health facilities. A policy of progressive deinstitutionalization, beginning in the early 1960s, resulted in a steep decline in hospital populations. The number of beds in Canadian mental hospitals fell from 47,633 in 1960 to 15,011 in 1976, a decrease of 68%.<sup>(19)</sup> In Greater Toronto, the number of long-term psychiatric hospital beds fell from 3,857 in 1960 to 761 in 1994, a decrease of 80%.<sup>(20)</sup>

Although it has been widely reported that deinstitutionalization led to a rise in homelessness, this claim has been disputed. For example, it has been found that in the United States “the contribution of deinstitutionalization to homelessness was marginal at best.”<sup>(21)</sup> Further, the Pathways Project reported that by the late 1990s, only 6% of homeless persons had been in a psychiatric facility in the 12-month period immediately prior to their homelessness.<sup>(22)</sup>

It was intended that deinstitutionalization be accompanied by a corresponding increase in the availability of community-based treatment and support services. This commitment was not fulfilled to the extent needed.<sup>(23)</sup> Further, during the 1990s, some Canadian

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(18) Patricia A. Zapf, Ronald Roesch, and Stephen D. Hart, “An Examination of the Relationship of Homelessness to Mental Disorder, Criminal Behaviour, and Health Care in a Pretrial Jail Population,” *The Canadian Journal of Psychiatry*, Vol. 41, No. 7, September 1996, p. 438.

(19) Begin *et al.* (1999), p. 30.

(20) British Columbia, Ministry of Social Development and Economic Security, *Homelessness – Causes & Effects (Volume 4): Background Report – A Profile and Policy Review of Homelessness in the Provinces of Ontario, Quebec and Alberta*, March 2001, p. 28.

(21) Begin *et al.* (1999), p. 45.

(22) Mental Health Policy Research Group (1998).

(23) British Columbia (2001), p. 28.

governments sought to control funding for healthcare<sup>(24)</sup> and community-based support services,<sup>(25)</sup> made social assistance more difficult to obtain,<sup>(26)</sup> and withdrew financial support for social housing.<sup>(27)</sup> It is arguable that the reduction in the provision of these services placed more individuals at risk of becoming homeless, and made it more difficult for homeless persons to acquire housing and to access services, including mental health services, necessary to reintegrate into society.<sup>(28)</sup>

## **B. Legal System Challenges – Police Services, Courts and Correctional Facilities**

As the numbers of homeless persons have increased in all large Canadian cities,<sup>(29)</sup> and both homelessness and mental illness are strong predictors of involvement with the criminal justice system,<sup>(30)</sup> it is not surprising that large numbers of homeless persons have had this type of experience. As noted above, homeless persons in Toronto are far more likely to spend time in a police station or jail than a psychiatric hospital.

Police services, courts, and correctional facilities are ill equipped to contend with these problems. Each evolved with a specific purpose and role, and none were designed to substitute for health and social services. Police officers may not be properly trained to deal with the complex needs of homeless persons and individuals with mental illnesses, and their powers under provincial mental health laws are restricted. Notwithstanding these limitations, in some communities police are forced to take on the role of mental health worker as their time spent dealing with individuals who have mental health problems has more than doubled.<sup>(31)</sup>

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(24) Barbara Murphy, *ON THE STREET – How We Created the Homeless*, J. Gordon Shillingford Publishing Inc., Winnipeg, 2000, pp. 123-124.

(25) British Columbia (2001), p. 29.

(26) Buckland *et al.* (2001), p. 14.

(27) City of Toronto, Mayor's Homelessness Action Task Force, *Taking Responsibility for Homelessness: An Action Plan for Toronto*, January 1999, p. 144.

(28) British Columbia (2001), p. 29.

(29) City of Toronto (1999), p. 19.

(30) British Columbia, Ministry of Social Development and Economic Security, *Homelessness – Causes & Effects (Volume 1): The Relationship between Homelessness and the Health, Social Services and Criminal Justice Systems: A Review of the Literature*, February 2001, p. 37.

(31) Canadian Mental Health Association, Ontario Division, Press Release, "Study Shows the Mentally Ill 'Criminalized' by lack of C[o]mmunity-based Services," Toronto, 24 September 2002, on-line: <http://www.cmha-tb.on.ca/articles-study%20shows.htm> (date accessed: 6 March 2003).

Organizations such as the Canadian Mental Health Association have argued that insufficient and underfunded local mental health services have contributed to an increased criminalization of persons with mental illness. Having viewed the findings of *Trends in Police Contact with Persons with Serious Mental Illness in London, Ontario*, they noted that “community mental health services haven’t had an increase in base budgets for more than a decade. That means people with mental illnesses and their families aren’t getting the ... community services they need to help them cope and that means more pressure on the police, hospitals and other emergency services.”<sup>(32)</sup> Ironically, while reduced community mental health services may cause more individuals to be conveyed to hospitals, beds are less available, as criminalization of individuals with mental illness has also resulted in fewer services for civil clients.<sup>(33)</sup> Moreover, when beds are available, homeless persons face the prospect of discharge to shelter facilities<sup>(34)</sup> that they may then be forced to leave.<sup>(35)</sup>

The legal system is similarly ill equipped. The mental disorder provisions of the *Criminal Code* were enacted to contend with offenders who are seriously affected by mental illness and either are unfit to stand trial due to their mental disorder or are not criminally responsible on account of mental disorder. However, while the changes proposed to these provisions<sup>(36)</sup> in response to the report of the House of Commons Standing Committee on Justice and Human Rights<sup>(37)</sup> may allow the legal system to deal with mentally disordered offenders more readily, they will be of little assistance to many homeless people or individuals with mental illness dealt with through a criminal process. Although provision is currently made for

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(32) *Ibid.*

(33) Ontario Ministry of Health and Long-Term Care, Forensic Mental Health Services Expert Advisory Panel, “Assessment, Treatment and Community Reintegration of the Mentally Disordered Offender – Final Report,” December 2002, p. 24.

(34) Hwang (2001), p. 231.

(35) Government of Ontario, Provincial Task Force on Homelessness, *Report of the Provincial Task Force on Homelessness*, October 1988, p. 4.

(36) See Department of Justice Canada, Backgrounder, “Measures to Modernize the Mental Disorder Provisions of the Criminal Code,” on-line: [http://canada.justice.gc.ca/en/news/nr/2004/doc\\_31146.html](http://canada.justice.gc.ca/en/news/nr/2004/doc_31146.html) (date accessed: 30 March 2004).

(37) See House of Commons, Standing Committee on Justice and Human Rights, Report of the Standing Committee on Justice and Human Rights, *Review of the Mental Disorder Provisions of the Criminal Code*, 1st Session, 37th Parliament, June 2002, on-line: <http://www.parl.gc.ca/InfoComDoc/37/1/JUST/Studies/Reports/JUSTRP14-e.htm> (date accessed: 8 April 2004).

specialized assessment, treatment and reintegration of mentally disordered offenders into society, these services are hampered by a chronic lack of resources<sup>(38)</sup> and may not be available to other offenders with mental illness.

Homeless persons, and persons with mental illnesses, are being detained in remand centres in Canada and the United States. Zapf, Roesch and Hart found that 7.8% of persons detained in the Vancouver Pretrial Service Centre had been homeless for most of the six-month period prior to their arrest. In New York City, 21% of inmates at a pretrial facility were homeless the night prior to their arrest, and 40% had been homeless at some point in the three years before their arrest.<sup>(39)</sup> Once imprisoned or otherwise held in the custody of the correctional system, however, their prospects are unimproved.

As discussed above, mental illness, substance abuse and suicide are more prevalent amongst offenders in federal institutions. It has also been found that the environment in many facilities may contribute to mental illness or addiction, the recurrence or worsening of symptoms of these disorders, and suicide. Moloughney reported that risks of violence and death, separation from family and friends, and worries about parole reviews or transfers to other facilities “can challenge one’s mental health. Individuals with existing mental health disorders will tend to have fewer personal resources to cope with stressors, resulting in the potential exacerbation of their disorders.”<sup>(40)</sup> Moreover, it has been established that “the inmate’s risk of acting in a self-damaging or suicidal manner is the product of a complex and fluctuating interaction among the prison environment, the inmate’s individual vulnerabilities, and current stresses.”<sup>(41)</sup>

Offenders, and particularly those with mental illnesses<sup>(42)</sup> or addiction, and those who were homeless prior to arrest,<sup>(43)</sup> face the prospect of homelessness upon release. Refusal to participate in discharge planning,<sup>(44)</sup> reduced availability of health and social services, and a lack of housing all contribute to this possibility. Regardless of whether these factors result in a first-

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(38) *Ibid.*

(39) Zapf, Roesch and Hart (1996), pp. 435 and 437.

(40) Moloughney (2004), p. S36.

(41) *Ibid.*, p. S48.

(42) Zapf, Roesch and Hart (1996), p. 436.

(43) *Ibid.*, p. 439.

(44) Government of Ontario (1988), p. 3.

time incidence of homelessness, or are part of a pattern of cyclical or chronic homelessness,<sup>(45)</sup> once back on the street the individual is again part of a community with a higher prevalence of mental illness and addiction, and a greater likelihood of contact with the criminal justice system.

## CONCLUSION

Homelessness is increasing. The debate over whether homelessness is a “pathway” to mental illness and substance abuse, or mental illness and substance abuse are “pathways” to homelessness, has not stemmed this tide. Recognition of the interconnectedness of mental illness, homelessness and the criminal justice system is a necessary first step in developing a course of action to address this growing social problem.

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(45) For a more detailed description of the different types of homelessness, refer to Begin *et al.* (1999), pp. 5-9.