The Stigma of Mental Illness:
An Inquiry into the Toronto Mental Health Court and whether it reduces the stigma of mental illness for those accused of crimes

by

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Abstract

In 1998, the first Mental Health Court in Canada was established in Toronto. Located in Old City Hall, the court is specialized to service individuals living with mental illness who come in conflict with the law. This thesis completes an exploratory study of the Toronto Mental Health Court. The two key objectives of the study are to determine the structure and functioning of Toronto Mental Health Court and to determine if and to what extent the court (structure) and its employees (functioning) address the stigma associated with individuals living with mental illness. This was accomplished by compiling observations of court proceedings; as well as interviewing employees who work within the Mental Health court and professionals from community agencies who advocate on behalf of individuals appearing before the court. Additionally, my research is also supported by reviewing documents on the Toronto Mental Health Court as well as other specialized mental health and drug courts in Canada and the United States of America.

This study provides an overview of the structure and function of the court. Bruce Link et al.'s theoretical perspective on stigma is utilized as it relates to individuals living with mental illness and to determine the presence of stigma in the Toronto Mental Health Court. Although the concept of a specialized court for individuals appears on the surface to reduce stigma, using Links et al. theoretical perspective to explain the findings in this study, it is argued that stigma is present in the both the structure and functioning of the Toronto Mental Health Court.

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Chapter One: Introduction

It is estimated that twenty-five percent of the 73,000 persons in custody in Ontario suffer from some form of mental illness. Nine percent of these individuals are believed to be living with a serious mental illness (Linden, 2002). Through my work, both in the Ottawa-Carleton Detention Centre and at the Ottawa courthouse, I became interested in understanding the experiences of accused individuals caught between the mental health and criminal justice systems. In these circumstances, individuals may not receive treatment because they are waiting for a fitness assessment. This assessment determines whether they are best treated in the mental health or criminal justice system. Many individuals suffering from mental illness come into contact with the criminal justice system and are held in provincial detention facilities. In my experience, these facilities focus on ensuring the safety and security within the institution rather than concerning themselves with the rehabilitation and treatment of accused individuals suffering from mental illness.

The negative stigma attached to individuals living with mental illness in the criminal justice system is an issue that has been discussed a great deal. In this exploratory study, I will examine how the Toronto Mental Health Court assists and works with individuals who are involved with both the mental health and criminal justice systems. By attaining a solid understanding of the organizational structure of the court and how it functions, I can assess if and how the accused who appear before the Mental Health Court are stigmatized.

Key Concepts and Terms

For the purpose of this thesis, the terms rehabilitation, treatment, deviance, stigma, structure and functioning will be used repeatedly. These terms can be interpreted in a number of different ways. I define them as follows:

Rehabilitation: For the purpose of my research, rehabilitation will be understood from a psychosocial rehabilitation perspective as "a therapeutic approach that encourages a mentally ill person to develop his or her fullest capacities through learning and environmental supports" (Bachrach, 1996). It is through effective psychosocial rehabilitation that an individual with mental illness can be successful in re-integrating back into the community.

Treatment: The act or method of providing someone with medical care (Webster's Dictionary, 1987). For the purpose of this study, treatment will be discussed as providing both medical (pharmacological) and psychosocial care to individuals who suffer from serious mental illness.

Deviance: Deviance can be defined as either primary or secondary deviance. Primary deviance occurs for a variety of different reasons, however, it does not lead to "an individual being labelled a deviant or for this individual to see themselves as deviant" (Brym, 1998 p.459). For the purpose of this study, deviance will be discussed in terms of secondary deviance, which is the "deviance [that] occurs after one has been labelled a deviant and starts to view oneself as a deviant" (Brym, 1998 p. 459).

Mental Illness: The term mental illness is discussed from both legal and social science perspectives. Section 16 of the Canadian Criminal Code describes mental illness as insanity. Insanity is legally understood as a state when "a person is incapable of appreciating the nature and quality of the act or omission or of knowing that it was wrong". The social science perspective on mental illness is that it is a biological and physiological abnormality, as well as a social status, because sociological criteria are integral to identifying mental illness (Bolaria, 2000).

Stigma: The concept of stigma, and the consequent stigmatization of individuals suffering from mental illness, is the focal point of my research. For the purpose of my study, stigma is defined as a stereotype attached to individuals suffering from mental illness, such as dangerousness and abnormality, which affects the way that society views this population. This term is further explored in Chapter 2 with a literature review designed to help understand the term stigma.

Structure: For the purpose of this thesis, structure is used as a way to describe the organization of the Toronto Mental Health Court.

Functioning: The word functioning is used to describe the daily operation of the Mental Health Court.

This introduction is divided into four sections, which are the foundation of my study. The first section outlines a brief history of the Mental Health System from institutionalization to the development of the Toronto Mental Health Court in 1998. The second section introduces the theoretical perspective held by Bruce Link et al. on stigma; it demonstrates how this perspective is used to understand stigma and its impact on the Toronto Mental Health Court. The third section reviews the methodological techniques that are used. The last section provides an overview on manner in which the results of my study will be reported.

History of the Mental Health System

Institutionalization

Institutionalization refers to the period in history when people with mental illness were placed in institutions as a means of social control. The origins of these institutions can be traced back to the mid-1700s in Western Europe, England and Scotland. Institutions were developed in North America by the early 1800s (Bartlett and Wright, 1999). Prior to this period, the treatment of mental illness was the responsibility of the family and it was strongly influenced by religious beliefs. Historically, imprisonment in state asylums and care by mental health professionals was a method of maintaining social order. Persons were incarcerated who were labeled abnormal, deviant and who stood outside socially constructed norms.[i] These individuals included the mentally ill, physically disabled, the elderly and women.[ii]

The asylum was a mechanism to control and reform deviance. Andrew Scull, a historical sociologist who has studied the rise of the asylum in North America, argues that institutionalization is an example of controlling deviance in modern society. During this time, individualism and productivity are emphasized as an important part of character. Consequently, those living with mental illness were not devalued based upon class or race, but rather because of their inability to be productive (Ingleby, 1983).

In 1831, legislation was passed in Upper Canada to develop an asylum for the insane. It was believed that in the asylum the mentally ill "would receive greater care and comfort than was possible in the common jail" (Hector, 2001, p. 59). However, the first official Canadian asylum, named the "Toronto Provincial Asylum," was not opened until 1850. David Wright, in his article *Mental Health Beginning in Ontario*, argues that:

> the opening of the Toronto Provincial Asylum began the changes of the social organization for the care and treatment of the mentally ill in Ontario. Superintendent Joseph Workman spent the next 22 years in his efforts to implement moral treatment for the mentally ill in Ontario (Wright, April 12, 2005).

Asylums, such as the one developed in Toronto, incarcerated patients living with mental illness as well as patients from various marginalized populations (i.e., physically disabled or women). By the late 19th century, the Toronto asylum was becoming overcrowded. Thus, four additional asylums were developed in Kingston, London, Hamilton and Orillia to meet the increasing number of individuals being institutionalized in the province (Wright, April 12, 2005). The growth of what later became know as the psychiatric hospital system continued until the early 1960s. The movement towards de-institutionalization began during the 1960s.

The De-institutionalization Movement

The De-institutionalization Movement was a well-intentioned movement aimed at re-integrating those historically labeled and stigmatized due to their chronic mental illness. It was made possible, in part, by the advent of the anti-psychiatry movement.[iii] De-institutionalization was also made possible through medical neuroleptic drugs in the 1950s (Simmons, 1990). In the United States and Britain, the shift towards deinstitutionalization began in the 1960s and 1970s. Canada followed this trend towards de-institutionalization somewhat later (Simmons, 1990). Decades before the de-institutionalization movement, a great deal of stress had been placed upon the psychiatric system in Canada. Mental health services were being overextended with overcrowded facilities and understaffed provincial psychiatric hospitals. Patients suffering from serious mental illness were spending their lives in the hospital and few treatments worked effectively (Wasylenki, 2001). By the late 1960s,

drug therapies allowed those who suffered from chronic mental illness to more effectively re-integrate back into the community and no longer depend on the institution. [iv]

Evolution of the Canadian Criminal Justice System and Mental Illness

Over the past few decades, the treatment of mentally ill individuals who have come into contact with the justice system has changed dramatically. Treatment has drifted away from universal detention (for an indefinite period of time) of individuals suffering from mental illness in mental health facilities or the correctional system. Until the 1990s, "*persons found not guilty by reason of insanity* were held at the pleasure of the Lieutenant Governor for an unspecified period of time" (Statistics Canada, 2003, p. 8). A milestone occurred in the 1991 Supreme Court of Canada ruling *R v. Swain.* In this ruling, the Court stated that automatic detention of a person found not guilty by reason of insanity without evaluating their dangerousness and/or the appropriateness of their disposition was a violation of the *Charter* (Statistics Canada, 2003). This case led to significant changes in the way individuals living with mental illness were handled in the Canadian criminal justice system. In 1992, the proclamation of Bill C-30 made significant amendments to the Criminal Code. This bill amended the Lieutenant Governor warrant system of keeping individuals suffering from mental illness incarcerated for an unspecified period of time and created a new Review Board system. Individuals who had previously been called not guilty by reason of insanity were now considered to be not criminally responsible on account of mental disorder (NCRMD) (Statistics Canada, 2003). The Review Board now had the responsibility to examine cases that involved assessing whether an individual was fit to stand trial and to complete annual reviews of those accused individuals classified as NCRMD.

The Supreme Court of Canada ruling on *R v. Winko (1999)* determined that only an accused individual considered to be a significant criminal threat to the public warranted being held in custody. If there was not enough evidence to substantiate that the accused was a significant threat, an absolute discharge must be granted by the Review Board (Statistics Canada, 2003).

Toronto Mental Health Court

Mental health courts, first established in 1980 in the United States of America (U.S.A), were modeled after existing drug courts. Since that time, the U.S.A has authorized the creation of 100 similar mental health courts (Schizophrenia Society of Canada, February 18, 2005). The Toronto Mental Health Court, developed in May of 1998 and designated to support the population in the greater Toronto area, is the first of its kind in Canada. This specialized court operates five days a week and focuses on providing fair and comprehensive treatment to people with mental illness who are in conflict with the law. It was created to meet the needs of "individuals who are better treated in the community than in the corrections system environment" (Schizophrenia Society of Canada, February 18, 2005).

In contrast to traditional criminal courts, the Toronto Mental Health Court is comprised of an interdisciplinary team of legal and mental health professionals (i.e., judge, lawyers, psychiatrist and mental health court support workers). The Toronto Mental Health Court is considered non-adversarial and specializes in working with this vulnerable population. Initially, the primary purpose of the court was to assess fitness issues; a person was sent to the Toronto Mental Health Court if their fitness to stand trial was in question[v]. The person was then typically placed on a Form 48 of the *Criminal Code*, otherwise known as an assessment order, and sent to this specialized court. Because the Centre for Addictions and Mental Health has a Brief Assessment Unit on site in the courthouse, the assessment can be completed in five or six hours (Gordon, Winter 2005). Previously, a judge would see the accused and remand them back into jail custody, where they would wait to go to the hospital to be assessed by a psychiatrist. After they were examined, they were returned to the jail to wait for another court date. The process took between 10 and 15 days (Gordon, Winter 2005).

In his article, "Closing the service gaps: Assisting persons with mental health issues," Justice Linden reports that role of the Toronto Mental Health Court has expanded from its initial mandate of dealing with fitness issues to include bail hearing, release, diversion applications and guilty pleas (Linden, 2002). By expediting the fitness issue process, individuals who are considered unfit and require a longer period of assessment go into hospital to receive

treatment much sooner than those in the mainstream criminal court system. Those accused who are found fit may have the option of having a bail hearing in the court and are sometimes released the same day. The bail process is expedited because mental health court support workers are located on-site to provide assistance with release planning (Gordon, Winter 2005).

Another option of the Toronto Mental Health Court is diversion from the criminal justice system to the mental health system. In cases that are appropriate, mental health court support workers offer clients the option of diversion. This provides the client the opportunity to develop a plan that will satisfy the requirements of the legal system as well as assist them in their rehabilitation. Court support workers, in collaboration with the Court Crown Attorney, develop conditions that the client must follow in order for their criminal charges to be withdrawn (Canadian Mental Health Association: Ontario, Winter, 2005).

Most of these individuals who appear before the Toronto Mental Health Court do not suffer from a severe mental illness, but fit the legal definition of insanity since they are not able "to understand the nature and consequence of their act" (Gordon, Winter 2005). These individuals are most often charged with relatively minor offences, such as theft or vandalism. Commonly, most of these individuals have come into conflict with the law because they have gone off their medication or are not following their treatment plans (Gordon, Winter 2005). It has been estimated that since the establishment of the court, duty counsel has assisted approximately 3,000 clients. In 2003, Gordon reported that in the past two years alone approximately 3,000 to 5,000 accused have appeared before the court (Gordon, Winter 2005). In examining the Toronto Mental Health Court, it is also important to note that individuals living with mental illness who commit violent offences still must go through the mainstream criminal court system.

Stigma – An Approach

In order to develop an approach to examine the presence of stigma in the structure and functioning of the Toronto Mental Health Court, I review different theoretical perspectives used to understand individuals living with mental illness and the negative

consequences that stigma may have on them. Through this examination, I decided to use Bruce Link et al.'s conceptualization of stigma to complete my study of the Toronto Mental Health Court. Link et al. (2001) argue that stigma is present through the simultaneous occurrence of four interrelated components:

1. Distinguishing and labeling differences between people. This occurs through assigning individuals to different categories.
2. Associating human difference with negative attributes. This occurs when a label is associated with an undesirable characteristic.
3. Separating "us" from "them", which is the belief that negatively labeled individuals are fundamentally different from others who do not share the label.
4. Loss of social status and discrimination due to negative labels associated with an individual.

I use Link et al.'s four criteria to operationalize the concept of stigma and determine whether stigma is present in the structure and functioning of the Mental Health Court. Lastly, Link et al. contends that the ability to stigmatize another is based upon social, political and economic power. Given the significance of power in stigmatization, in my research I also examine how power structures and relations effect the stigmatization of individuals living with mental illness who appear before the Mental Health Court.

Another factor that is important in understanding the impact of stigma on accused who appear before the court is the structural factors relating to race, class and gender. However, given the nature and direction of my research, I do not focus on the impact of these structures. Issues of race, class and gender are only looked at through demographics of the accused compiled through observational research. As such, this may be an area of future research on the Toronto Mental Health Court.

Methodology

I use a qualitative research framework in order to complete an exploratory study of the Toronto Mental Health Court, focusing specifically on how the court encounters stigma and deals with the stigmatization of individuals living with mental illness. I use both

observational research and qualitative interviews with employees of the court and external agencies outside of the Toronto Mental Health Court that advocate for the accused. The qualitative research methodology of the study is discussed in further detail in Chapter Three.

Results

The results section of my study is divided into two chapters. The first section, in Chapter Four, concentrates on reviewing research findings on the structure and functioning of the Toronto Mental Health Court. This chapter provides a foundation and detailed outline of how the Toronto Mental Health Court works showing how it is structured and how it functions on a daily basis in dealing with individuals with mental illness. Building on this understanding, Chapter Five reflects on the impact the court has on stigma related to mental illness. This chapter concentrates on the findings of my observations of the court and participants' responses. Research findings are examined by using Link et al.'s conceptualization of stigma to determine the presence of stigma in the structure and functioning of the Toronto Mental Health Court. Through this research and analysis I determine if stigma is present in the structure and functioning of the court and if the Toronto Mental Health Court reduces the stigma of mental illness for those accused of crime.

[i] In essence all norms are socially constructed. Norms are considered social rules that people believe themselves and others should follow. As such, norms constrain people's choices. If they do not follow these norms they may have to face the consequence of being regarded as deviant (Brym, 1998, p.490).

[ii] During the Victorian Era of the nineteenth century women in state asylums outnumbered the men. Many of these women were incarcerated and considered deviant because they had been labeled as hysterical. A common belief of the time was that females were dominated by their body and therefore weaker and more prone to illness then men (Mitchinson, 1991, p.280).

[iii] The anti-psychiatry movement occurred in the 1960s as a rights movement, where a variety of groups united in their belief that psychiatry would put undue influence over the mentally ill through medical monopolization (Sedgwick, 1982).

[iv] The objective of re-integration was to assist individuals in finding appropriate housing, employment and community supports, in order to alleviate some of the pressure in the emergency shelter system and social service assistance programs (Ontario Multi-Faith Council, February 28, 2005).

[v] One is deemed unfit to stand when they are not capable of instructing counsel or of comprehending the nature and consequence of the trial (Statistics Canada, 2003).

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Chapter Two: Understanding Stigma

This chapter is dedicated to determining the appropriate theoretical approach to use in examining the presence of stigma in the structure and functioning of the Toronto Mental Health Court. The chapter is comprised of a literature review examining different theoretical perspectives on stigma and its impact on individuals living with mental illness, and on the consequences of stigma for this population. The issue of stigmatization has been examined by a number of different disciplines including philosophy, sociology and psychology. Stigmatization can occur in a variety of different circumstances as it relates to race, class, gender, criminal record etc. This literature review will focus on stigma as it relates to the perception of mental illness. I will review different theoretical perspectives to examine individuals living with mental illness and the negative consequence that stigma may have on them. This literature review will examine the evolution of stigma from ancient times to modern day. The chapter is organized into three major sections. The first section is an historical overview of the conception of stigma and mental illness in ancient Greece, the Medieval period and the Renaissance era. The second section examines stigma as it relates to the development of the institution. With the development of the institution came a number of critiques from theorists involved in the anti-psychiatry movement. These theoretical perspectives have been critical to understanding stigma and the impact that it has on individuals living with mental illness. The last section of the literature review concentrates on examining contemporary theoretical perspectives on stigma related to mental illness. It is from this detailed review that I decided that the most appropriate approach to examining stigma in the Toronto Mental Health Court is by utilizing the contemporary perspective of Bruce Link et al.

Historical Conceptions of Stigma and Mental Illness

In order to understand the roots of stigma and the origins of its relationship with mental illness it is critical to examine the significance of the term 'stigma' in ancient Greece,

and during the Medieval and Renaissance period. Identifying the roots of stigma and mental illness will allow for a more substantive understanding of how stigma has evolved over time.

Stigma and Ancient Greece

The word stigma has a close association with the Christian religious term 'stigmata.' Stigmata refers to marks that are similar to the wounds of the crucified body of Jesus Christ (Webster's Dictionary, 1987). Although they do not mean the same thing, stigma is considered to be a "social construct indicating disgrace that, at the same time, identifies the bearer." (Simmie, 2002, p.56) According to Simon (1992), a considerable amount of stigma was linked to mental illness in ancient Greece, as stigma was closely associated with shame. Stigmatization was "the practice of burning or cutting a mark into the flesh of criminals and slaves." These marks could be used to set these people apart from the general population (Simmie, 2002, p.56; Goffman, 1963). At this time, the wounds were identified as a mark of shame. However, at the same time the term stigma was not automatically considered negative and could also be used in a positive manner. Stigma was viewed as a religious metaphor in which the term could be used positively – first as a "sign of service to God, and the second, the sense of a wound inflicted in the course of serving as a soldier of Christ" (Simon, 1992, p.30).

A number of Greek sources on madness and mental illness are associated with shame and humiliation (Dobbs 1951; Ducey and Simon 1975; Simon 1978 as quoted in Simon 1992). There is also a very present notion that an afflicted individual is 'polluted'. Therefore, the 'polluted' individual is often shamed toward isolation so that individual does not 'pollute' others (Simon, 1992). In addition, madness is a common theme in Greek tragedy, where it is often romanticized. For instance, in Sophocles' *Ajax* the main character's mental illness is a cause of shame, humiliation and embarrassment. Although he is not considered to be responsible for his illness, the tragedy revolves around Ajax's guilt and social rejection because of the behavior that he displayed during his delusions (Simon, 1992). In the Greek tragedy by Euripedes, the *Madness of Hercules* (known in Greek as *Hercules Furen*), Hercules' madness overpowers him and prompts him to kill his wife and children. This fit of madness was apparently sent by the goddess Hera. Through the madness which Hera

bestowed on him he "hallucinate[s] that the children clinging to him [are] the sons of his enemy" and he reacts by killing his wife and children (Mythologica: A Treasury of World Myths and Legends, 2003, p.132)[i] The compelling dilemma of the play takes place at a time when Hercules begins to recover from this madness. He initially contemplates suicide to pay for the action he committed while 'mentally ill'; but then decides to live after his friend Theseus promises to purify him and rid him of this pollution of madness (Papadopoulou, 2004).

In sum, the Greek perspective on mental illness was related to a sense of shame and disgrace. A more biological approach is taken during the next significant period of development of stigmas as it relates to mental illness in the Medieval and Renaissance Eras.

The Renaissance Era and Medieval Era and Stigma of Mental Illness

There are two main perspectives used to understand mental illness during the Medieval and Renaissance times. The first perspective is that mental illness is related to a disharmony among four humors[ii], which leads to the overflow of black bile referred to as melancholia. Melancholia was used to describe one of the primary forms of madness in early times. According to traditional physiology, one's state of well-being depends on the balance of these four fluids (humors) (Zydowicz, December 1999).

The second perspective of this time is that individuals with mental illness are considered examples of the frailty of man and the lowest order of humankind. Therefore, rather than being hidden they are exhibited as examples of those who are conflicted between evil and the atonement achieved through grace (Mora, 1992). It is difficult to translate behavioral characteristics of what was then considered to be 'madness' to modern psychological conditions since it appears that other physiological problems such as lesions, malnutrition and infections may have been the cause of these illnesses.

Individuals living with mental illness were accepted as part of society and left to either wander the streets or be restrained by family members at home. Measures used to restrain these individuals were often cruel and brutal because the concept of individual freedom was

unknown. Unmanageable cases and dangerous individuals were turned over to authorities to be confined to dungeons and jail, sometimes for life. A small number of unmanageable individuals were looked after by religious orders, which placed them in institutions considered to be a combination of hospital, sheltered workshop and penitentiary (Mora, 1992).

At that time, the term penitentiary was understood as a place to do penance for alleged sins. The meaning later changed to describe a place where people were punished and did time for crimes they committed. Additionally, during this time, mental illness was non-discriminatory towards any social strata, considering that individuals of various socio-economic backgrounds could be affected by illness. This fact is exemplified through the lives of Charles VI, King of France, and George III, King of England, who were widely known as suffering from mental illness or being 'mad'.

Charles VI reigned as the King of France from 1380-1422. He was known as 'Charles the Mad', since he had suffered from episodes of what was called insanity during his time in power. During his reign, Charles VI was said to suffer from "intermittent episodes of depression and excitement, punctuated by long periods of inactivity followed by sudden outbursts, either belligerent, violent, revengeful, or grandiose" (Mora, 1992, p.49). The illness of Charles VI was well known to all of his subjects who considered it to be the will of God, although a majority of his subjects considered his illness to be inappropriate for royalty, as it deviated from royal status. His condition was viewed predominantly from a religious perspective, and his subjects viewed him in constant pity. As such, throughout his reign his subjects continued to consider him "Charles the Beloved" (Mora, 1992, p.50). His first known episode of madness was in 1392 when his constable was a victim of an attempted murder. Although the constable survived the attack, Charles VI was determined to extract revenge and sent off an army to find the would-be assassin. However, one day when one of the Kings soldiers asked him to turn back, he was said to have gone mad and attacked his own soldiers (Palmer, 1972). Following this incident, Charles' Uncle Philip II, Duke of Burgundy assumed regency dismissing Charles and his constable. The stigma attached to Charles VI was that of pity, exemplified by the mass prayers and processions that were held

in order to bring about his recovery (Mora, 1992).

Contrary to Charles VI of France, George III's mental illness was not common knowledge to his subjects. George III reigned as King of Great Britain and of Ireland from 1760 to 1820. During the later part of his reign he began to suffer from a persistent mental illness, and he had attacks in 1788, 1801 and 1804 (Fry, 2006). His mental and nervous disorders were considered to be a consequence of the blood disorder known as porphyria. In 1810, George III became very ill, which made him become permanently insane; George III was described as having delusions, talking for hours without stopping and speaking to angels. In 1811, King Georges III's condition deteriorated to the point that he was confined in Windsor Castle where he stayed until his death (Ross, 2005).

Stigma endures as George III's illness was featured in a play by Alan Bennett called "The Madness of King George III" (1991) and later in the 1994 film "The Madness of King George". Even after the passage of 200 years, the stigma associated with King George's illness was featured in a contemporary play, influencing present day perceptions of mental illness and further precipitating stigmatization.

The Institution and Stigma

Prior to the establishment of the asylum, individuals living with mental illness were the responsibility of their families. In cases where the family was unable to take care of their loved ones, local churches were responsible. The introduction of the Poor Law in 1601 formally outlined the responsibility of every church to support those who were unable to take care of themselves (Rushton, 1998). As discussed in detail in the previous chapter, the establishment of the institution can be traced back to the mid-1700s in Western Europe, England and Scotland. Institutions were developed in North America by the early 1800s (Bartlett and Wright, 1999). Institutions also known as insane asylums were used as a means to maintain social control and to reform deviance. Asylums were developed across England, Europe and North America. The growth of asylums was associated with critical reflections of the incarceration of people understood to be mad and the branch of medical science used to understand them – psychiatry. These critiques were part of a movement against psychiatry

beginning in the 1960s, when a number of scholars began to theorize about the impact of the label of mental illness on incarcerated individuals and examine societal understanding of mental illness. Erving Goffman, Thomas Szasz, Ronald D. Laing and Thomas Scheff were the primary theorists involved in the anti-psychiatry movement. What follows is a review and appreciation of those authors who set out to better understand the meaning of the mental illness label.

E. Goffman

Erving Goffman (a Canadian-born sociologist) is a very influential figure in the anti-psychiatry movement. His interests in the role that social conception plays in large institutions allowed him to become a visiting researcher at the St. Elizabeth's Hospital in Washington D.C. from 1955 to 1956. For his research, he placed himself metaphorically in the position of a mental patient at the hospital. His work helps readers to understand institutionalization from the perspective of the patient, and the degradation and humiliation patients experience upon receiving psychiatric treatment (Everett, 2000). It is from this research that he published *Asylums: Essays on the Social Situation of Mental Patients and other Inmates* (1961). He argued that any large closed institution, such as a mental asylum, represented a unique social system that is characterized by several features, including locked doors, barbed wire, high walls etc. The result is to restrict social interaction with the outside.

Goffman discusses five groupings of these institutions. The first institution is one that cares for the incapable and harmless, such as the blind and aged. Secondly, there are institutions that assist those incapable of self care, such as the mentally ill. Thirdly, there are institutions designed to protect the community, such as jails. Fourthly, there are institutions established for education and training, such as boarding schools, and lastly, there are institutions that are established as training stations for religious purposes, such as convents (Goffman, 1961). Goffman believes that the internal dynamics of any institution are ordered towards the smooth functioning of the institution itself and not towards the therapeutic needs of the individual patient. Once in the asylum, Goffman argues that patients adopt particular roles that are necessary to their recovery. He coined the term 'total institution' as a way to describe those types of social institution where the internal dynamics of the institution take

priority over anything else. Goffman contends that within the total institution there exists a split between management, supervisory staff and patients (Goffman, 1961). Goffman defines the total institution as "a place of residence and work where a large number of similarly situated individuals, cut off from the wider society for an appreciable period of time, together live an enclosed, formally administered round life" (Goffman, 1961, p. xiii).

His work allows for an inside view of the experience of mental patients and its impact on them. From his research, Goffman asserts that the medical model, which only focuses on the patient, alters reality to the extent that "society's official view is that inmates of the mental hospital are there primarily because they are suffering from mental illness. However, to the degree that the 'mentally ill' outside hospitals numerically approach or surpass those inside the hospital one could say that mental patients distinctively suffer not from mental illness, but from contingencies" (Goffman, 1961, p.135). In this way one can not simply say that people who are institutionalized are individuals living with mental illness. As such, another factor must be present for these individuals to come into contact with the institution. For instance, they may have committed an offense or pose a danger to themselves or others. This is demonstrated by the fact that a number of individuals living with mental illness are not institutionalized.

Similar to other theorists who discuss labeling, Goffman uses the concept of 'career' when explaining the deviant socialization process. Accordingly, he believes (1961, p.168):

> The moral career of a person of a given social category involves a standard sequence of changes in a way of conceiving of selves, including importantly his own. These half-buried lines of development can be followed by studying moral experiences... that is, happening[s] which mark a turning point to which the person views the world... although the particularities of this view may be difficult to establish...By taking note of moral experiences and overt personal strands, one can obtain a relatively objective tracing of relatively subjective matters. Each moral career, and behind this, each self, occurs within the confine of an institutional system...The self can then be seen as something that resides in the arrangements prevailing in a social system for its members... The self dwells in the pattern of social control that is exerted in connection with the person by himself and those around him. The special kind of institutional

does not so much support the self as constitute it.

In 1963, Goffman wrote *Stigma: Notes on the Management of Spoiled Identity.* In this work, he argues that society categorizes people into 'normal' and 'stigmatized'. He contends that an individual becomes 'stigmatized' when he or she possesses "an attribute that makes him different from others in the category" and the social group considers the attribute different or deviant. Such an attribute is considered to constitute stigma. The attribute is not necessarily good or bad. The attribute becomes a stigma based upon the social response that it creates. As such, the term 'stigma' refers to an attribute that discredits the person that possesses the attribute. However, Goffman argues that it is important to note that an attribute that stigmatizes one person does not necessarily stigmatize another. Thus, it is not the attribute that creates the stigma but the relationship between the person and the attribute (1963).

It was through Goffman's work in the asylum and theories regarding stigma that other sociologists are influenced to evaluate the impact of the 'total institution' on people who are mentally disordered in psychiatric institutions. Aspects identified in Goffman's work have been central to the conceptualization and defining of stigma. Goffman's work focuses on the role of identity and the gap between 'virtual social identity', what a person ought to be, or 'actual social identity', what a person actually is (1963). According to Goffman, anyone who has a gap between these two identities is stigmatized.

In Goffman's work there are essentially two different categories of stigma. Discredited stigmas occur where individuals perceive a difference between themselves and others, such as a paraplegic or someone who is physically disfigured. The other type of stigma that is discreditable is stigma where difference is neither known to others nor can be perceived by them. An example of this would be a Jewish person posing as a Christian person or a Christian passing as a Jewish person. It is important to note that Goffman contends that everyone can be stigmatized at any point in their life, where stigma is largely situational and based upon the environment (Ritzer, 2000). The focus of Goffman's book is the issue of 'mixed contact', which he identifies as the point of time in which stigmatized and normal individuals are in the same social situation (1963, p.12). People living with mental illness

can experience discreditable stigma since their illness is not readily visible. As such, the difference between an individual living with a mental illness and an individual who is mentally well can not be detected by others nor perceived by them through an individual's physical appearance.

Thomas Szasz

In Thomas Szasz's book *The Myth of Mental Illness*, he argues that there is no such thing as mental illness. In this book, he contends that the concept of mental illness is both misleading and erroneous. His argument concentrates on comparing physical illness to mental illness, describing bodily disease as real and "mental illness as counterfeit or metaphorical illness" (34). He believes that illness can only affect the body and occurs when a person suffers from an abnormality or malfunction of their body. As such, he concludes that both physical and mental illnesses are determined through clearly defined norms, thus illness is determined through deviation from the norms. Norms for physical illness are determined though physiological terms; norms used to identify mental illness are defined by psycho-social, ethical and legal concepts. In terms of mental illness, Szasz indicates that either the person (patient) himself or someone other then the patient, including a medical professional, determines deviation. Once a person is identified as having a mental illness a psychiatrist becomes involved as a remedy to correct this deviation (Szasz, 1960). He deems psychiatrists to be the experts in differentiating illness from non-illness. Thus, Szasz's perspective empowers the role of psychiatry as a profession. That is, an individual who experiences episodes of sadness, suicidal ideation and homicidal ideation is unlikely to categorize him- or herself as mentally ill; rather, it is a label suggested by someone else, usually a psychiatric professional.

Szasz contends that medical diagnoses are indicative of illness, whereas psychiatric diagnoses act as stigmatizing labels. He believes that what is considered mental illness should be seen as an expression of an individual's struggle to cope with problems. In this regard, Szasz argues that mental illness should be considered a conventional myth, and that the diagnosis of mental illness is merely a stigmatizing label used by the medical community as a power and control mechanism. That is, human problems and situations are changed into

"specialized technical 'problems' to be 'solved' by so-called mental health professionals" (Szasz, 1970, p.5-6). This is especially visible in affluent Western countries which consider all the 'problems of living' as psychiatric diseases and expect those with a mental illness diagnosis to be mentally ill (Szasz, 1970).

Szasz argues that the term mental illness is merely a metaphor for a medical disorder. He argues that mental illness or disease of the mind is perceived and equated by society as equaling disease of the brain. Szasz bases his argument on semantics, finding that the literal meaning for the word 'disease' is "a condition of the body, or some part of organ of the body, in which its functions are disturbed or deranged" (Szasz, 2000). Szasz argues that the term mental disease can only be considered disease in a metaphorical sense as it is used to describe thoughts, feelings and behaviors which are considered 'undesirable'. Szasz believes that it would be a semantic error to classify an individual's undesirable thoughts, feelings and behaviours as disease. He argues that physical diseases are biologically constructed and that psychiatric disorders are socially constructed. He would argue that individuals with actual physiological problems who have brain or neurological defects (such as Parkinson's) are ill because they experience actual physiological defects. However, individuals with mental disease whose symptoms are bad behavior are only metaphorically ill (Szasz, 2000). He concludes that identifying and classifying undesirable behavior as disease provides an ideological justification for state-sponsored social control. He believes that it is this corruption and misconception of language with terms like disease that curtains the freedom and responsibility of those deemed ill. The goal of Szasz's perspective is for mental illness to be considered to be "an expression of man's struggle with problems of how he should live", rather than as a disease (Szasz, 1960, p.116).

Szasz's book *The Manufacture of Madness* (1970) is a continuation of his first book the *Myth of Mental Illness*. This work attempts to demonstrate that the ethical convictions and social arrangements that the concept of mental illness is based upon are "an immoral ideology of intolerance". He does this by comparing the stigma associated with witchcraft in the middle ages and the persecution that witches suffered to the label of mental illness and the persecution that mental patients have endured due to the stigma attached to this label. Szasz

states (1970, p. xvii):

> We have been warned time and time again, an injustice done to one—especially in a society that aspires to be free—is an injustice done to all. In my opinion, the "mental health" in a sense of spiritual well being—can not be improved by slogans, drugs, community mental health centers, or even with the billions of dollars expanded on a "war on mental illness." The principle problem in psychiatry has always been, and still is, violence: the threatened and feared violence of the "madman," and the actual counter violence of society and the psychiatrist against him. The result is the dehumanization, oppression, and persecution of the citizen branded 'mentally ill' (Herman, 1985, p.28).

Although first mentioned in *The Myth of Mental Illness,* another important perspective of Szasz as it relates to this discussion of stigma are his views on the danger of being diagnosed mentally ill. He explains that a person labeled mentally ill is more likely to be deemed a danger to themselves or others as compared to a person who has not been labeled. Therefore, it is the role of the psychiatrist to control mental illness. He finds that mental illness implies dangerousness and rationalizes the need for and use of psychiatric coercion (Szasz, 2003). Like a number of his works before this time, Szasz's article "Psychiatry and the Control of Dangerousness: On the apostrophic function of the term 'mental illness'" describes his views of the role of psychiatry and the social control of the state of individuals with mental illness.

Szasz is open to the practice of psychiatry so long as it is a voluntary process and does not involve coercion. He contends that the practice of psychiatry should be a contractual relationship between consenting individuals, and that there should be no state involvement. He believes strongly that forceful state involvement is incompatible with a free society and one's personal autonomy. The consequence that is faced by getting rid of compulsory treatment is that we may have more people with impaired health or even those who may choose to kill themselves. Szasz recognizes this consequence. However, he continues to believe that freedom of choice is something that should also allow for a person to make the wrong choice. Szasz states "we are too uptight about suicide to recognize that killing oneself is sometimes a reasonable and right thing to do... it ought to be treated as an act that falls outside the scope of interference by the state" (Szasz, 2003, p.228). Thus, Szasz viewed psychiatric practice as an infringement of an individual's civil liberties.

R.D. Laing

British psychiatrist R.D. Laing was born in Scotland. He attended Glasgow University where he studied medicine and later specialized in psychiatry. He spent a number of years working as a psychiatrist in the army where he developed an interest in communicating with individuals in distress. Later Laing worked in a hospital where he began to intensively study and write about mental illness and the experience of psychosis. He is best known as an influential figure associated with the anti-psychiatry movement, though like many other theorists of the time, he rejected this label.

Laing concentrates primarily on working with individuals suffering from schizophrenia. His work has been beneficial in understanding mental illness, specifically how an individual experiences psychosis. He focuses on determining the cause and treatment of mental illness. It is important to note that Laing also denies the existence of mental illness. Like Thomas Szasz (1970 and 1974), he believes that mental illness cannot only be explained through genetics or organic explanations.

His first major work, *The Divided Self: An Existential Study in Sanity and Madness* (1960), is considered to be the first recognized critique of psychiatry (Everett, 2000). Laing's book focuses on his research with individuals living with schizophrenia. His research concludes that mentally ill individuals have reasons, either good or bad, for behaving in the manner that they do. He argues that in order for individuals with schizophrenia to deal with their illness, their therapist should assist them to reconstruct the world as they perceive it to be. Thus, Laing believes that the therapist should determine that the person's 'strange behavior' is attributed to their experiences and existence in the world (Layder, 1994, p.79).

Laing uses existential-phenomenological methods to describe the experience of schizoid and schizophrenic individuals and the way to which they experience themselves in their world. He uses the terminology of 'ontological security' and 'ontological insecurity' as a method of understanding the experience of schizophrenics. The word ontology is used to describe "being" in the world. Thus, ontological security and ontological insecurity are used to

describe two different ways of experiencing oneself and the world. Ontological security, refers to the 'normal' state of being, where an ontologically insecure individual is considered to be "pre-occupied with preserving rather than gratifying himself: the ordinary circumstance of living threaten his low threshold of security" (1960, p.42). He believes that ontological security is achieved as a result of normal child rearing processes and physical development (Howarth-William, 1977). Laing describes ontological insecurity, as a condition often expressed as 'being dead', by people who are clearly still physically alive. Accordingly, Laing contends that ontologically insecure individuals face three different forms of anxiety: engulfment, implosion and petrication (p.43). He describes the experience of an individual living with schizophrenia or schizoid behaviour as ontologically insecure.

Laing contends schizophrenics should be viewed as individuals above all else. He argues that these individuals could be better understood as existing within a series of connections and social relationships (nexuses). These nexuses are the most important factors in understanding mental illness from the perspective of the sufferer. Laing argues that 'illness' is reflective of the quality of relationships a person has in their nexus and within this nexus persons experience what he describes as their "problems of living" (Layder, 1994, p.79).

He continues to discuss the idea of the nexus and social relationships in his most controversial book, *Sanity, Madness and the Family* (1964), which he wrote in collaboration with Esterton. This book focused on examining accounts of families of individuals with schizophrenia by looking at eleven different families in which a woman had schizophrenia. They accomplish this by examining three components: examining each individual family member, examining the relationship between individuals in the family and examining the family as a system (1964). They evaluate the way in which each family member interacts and communicates with one another. It is through this work and examination of the family nexus that Laing and Esterton conclude that schizophrenia is not something inherited; rather the family is associated with the development of a person's madness. This occurs in situations "where a person's true feelings and wishes are being thwarted by other family members and where communications are confused or ambiguous" (Layder, 1994, p.79). In the cases of the women studied, it was found that their mental breakdowns could be explained by the lack of

autonomy and poor sense of personal security they experienced based on their setting and family history. Therefore, a person becomes what they become (mentally ill) as a strategy to cope with their intolerable situation and as a method to preserve the world as it appeared to them (Layder, 1994).

Laing's views were heavily influenced by existential philosophy. Existentialism focuses on human existance itself and on a person's being in the world. Existential philospher Jean-Paul Sartre (1966) argues that "people are free to choose what they are and what they will become" an approach which was contrary to the psychiatric orthodoxy of the time (Layder, 1994, p.78).

Thomas Scheff

Thomas Scheff is a theorist who was greatly influenced by Goffman's ideas. In 1966 Scheff wrote *Being Mentally Ill: A Sociological Theory*, and in 1975 he wrote *Labeling Madness*. Slight modifications were made to his first book in 1984. This first book is groundbreaking and made him one of the most predominant theorists to discuss the labeling process. The labeling process is one by which society defines individual behaviors as examples of mental illness and an individual as mentally ill (Tausig et al., 1999). Past studies regarding mental illness focused on the motivating factors for people to violate the laws and social norms. The goal of the research was to determine the social and psychological characteristics of an individual likely to commit a deviant act.

Contrary to the medical model of mental illness, Scheff's Societal Reaction Model/ Labeling Theory focuses on how society reacts to deviance rather than the deviant. That is, "whether or not a behaviour is [considered] deviant depends on how others define and react to it in a particular setting" (Bolaria, 2000, p.408). His work applies the societal reaction model to a study of the mentally ill. He argues that a number of psychiatric symptoms can be viewed as behaviors that do not conform to society's agreed upon norms. He contends that once someone breaks a societal rule that is accepted by most everyone, they can be seen as displaying very bizarre or unnatural behavior. These types of societal rules are defined as residual rules. When residual rules are violated, an individual is known to engage in residual

rule breaking. Scheff hypothesizes that residual rule breaking as it relates to mental illness is due to "fundamentally diverse sources (that is organic, psychological, situations of stress, volitional acts of innovation of defiance)" (Scheff, 1975, p.9).

In some cases, people react to the residual rule breaking or odd behavior by contacting the authorities that arrange for these individuals to undergo a psychiatric assessment. Once persons are formally identified as mentally ill, the label can significantly impact their life. According to Scheff, misconceptions and stereotypes of mental illness are learned at early stages of life, and these stereotypes are repetitively reaffirmed through ordinary social interactions and depictions of mental illness in the media (Corrigan, 2005). Scheff's theory sets out to describe "the way that society reacts to 'mental illness' and how this reaction contributes to the problem" of labeling. It is further believed that the label of mental illness elicits negative and popular reactions to individuals including those of "fear and disgust leading people to minimize contact and distancing themselves from anyone displaying undesirable behaviors" (Corrigan, 2005, p.15).

Evidence to support Scheff's labeling theory is provided by a study completed by David Rosenhan in 1973 entitled *On Being Sane in Insane Places.* Rosenhan's study questions whether sane people can be identified when eight pseudo-patients are placed in a mental hospital. Pseudo-patients came from a variety of backgrounds ranging from psychologists, pediatricians and housewives. Pseudo-patients all made appointments at a variety of different hospitals all reporting the same falsified symptoms of hearing voices. Other than falsifying names, symptoms and, in some cases vocation, no further changes were made to the person's personal history. When the pseudo-patients were finally admitted to the psych-ward, they stopped their simulation of abnormal symptoms and acted as they normally would. Although, pseudo-patients demonstrated no other symptoms of illness during their stay, their sanity was never detected. Rather, they were labeled as schizophrenic. Once labeled as schizophrenic they were unable to overcome the label and other mental health professional perceptions of them had been tainted. As Rosenhan highlights, "once a person is designated abnormal, all of his other behaviors and characteristics are colored by that label....the label is so powerful that many of the pseudo patients' normal behaviors were overlooked entirely or

misinterpreted profoundly" (Rosenhan, 1973, p. 255). As a result, Rosenhan concludes that we are unable to identify the difference between 'sane' or 'insane'. It is clear that labeling plays a big role in the way to which 'patients' are treated as incurable. This study further justifies Scheff's argument that based on professional socialization, financial incentives and ideological commitment to the medical model, psychiatrists have the tendency to diagnose and label illness despite at times being uncertain (Corrigan, 2005).

Contemporary Conceptions of Stigma

Although the process of stigmatization no longer entails physically branding a person, there is an invisible stamp of 'the other' on individuals who have been diagnosed with mental illness. In November 2004, Senator Michael Kirby presented *Mental Illness and Addiction: Overview of Policies and Programs in Canada*, an interim report on Mental Health to the Standing Senate Committee on Social Affairs Science and Technology. Chapter three of this report discusses stigma as it relates to individuals with mental illness. The report defines stigma as "a sign of disgrace or discredit, which sets a person apart from others" (Kirby Report, November 2004).

The focus of the Kirby report is on stigma as it relates to discrimination. Stigma and discrimination are two concepts that are interrelated in creating a continuum that connects "the development of negative stereotypes to actual discriminatory behavior towards people with mental illness". Three stages describe the process by which stigmatization is linked to discrimination: stereotyping, development of prejudice and practice of discrimination. Stereotyping occurs when a negative belief is held about a group such as the dangerousness of an individual suffering from mental illness. Prejudice occurs when there is agreement with the belief resulting in a negative emotional reaction, such as fear. Lastly, discrimination occurs as a response to prejudice, such as when a particular population is avoided based upon a prejudice. The Kirby report demonstrates the impact that different negative labels can have on individuals who suffer from mental illness. The report points to commonly identified stereotypes associated with this population such as: 'people with mental illness are dangerous and should be avoided' and that 'there is little hope of recovering from mental illness' (Kirby Report, November 2004).

Cognitive Behavioral Approach to Stigma: Public and Self- Stigmatization

The common social psychological approach to understanding stigma is the cognitive behavioral. The cognitive behavioral approach to stigmatization elaborates on two forms: public stigmatization and self-stigmatization. Both public stigma and self-stigma are examined through stereotype, prejudice and discrimination. Public stigmatization is considered to be the way the general public reacts to a group based on the stigma associated with the group. Conversely, self-stigmatization occurs when an individual living with mental illness internalizes the negative labels associated with mental illness and turns against him- or herself (Kirby Report, November 2004). In order to fully understand the models of public and self-stigma, it is crucial to examine the impact which it has, especially the negative impact, on those who are labeled as mentally ill. Although public stigma most significantly affects individuals labeled with mental illness it also impacts the individual's family, friends and community at large (Corrigan, 2005).

Corrigan also notes three negative consequences of public stigma that are encountered in the daily life of individuals with mental illness. They include: the loss of rightful life opportunity, the reaction of the criminal justice system and the reaction of the general healthcare system. In regards to the loss of rightful life opportunity due to stigma, individuals with mental illness encounter difficulties attaining competitive employment opportunities. Additionally, they struggle to maintain independent housing. In fact, research has found that 60 percent of individuals living with mental health illness are unemployed and a quarter of them live close to the poverty line (Corrigan, 2005). Evidence points to an increase in the number of individuals with mental illness caught in the criminal justice system. Consequently, the criminalization of individuals living with mental illness is associated with the increased prevalence of these individuals in jails. It has been found that a person exhibiting symptoms of mental illness is more likely than others to be arrested by the police. With regards to the general health care system, Corrigan contends that individuals with mental illness receive less efficient care than do those who do not have this label. Research completed in the United States concludes that individuals with mental illness were less likely to access insurance benefits than those who did not have mental illness.

Predictably, individuals living with mental illness who self-stigmatize and believe negative stereotypes and prejudices associated with the label placed upon them will face decreased self-esteem and will believe they are less valued because they have the label of having a psychiatric diagnosis. It is apparent that individuals who self-stereotype and self-discriminate will suffer decreased quality of life, hindering their future (Corrigan, 2005).

Societal Levels of Stigma: Institutional Policies vs. Social Structures

Another contemporary view of importance when studying societal levels of stigma is the cognitive behavioural condition. Contemporary sociologists have found that it is not only important to consider stigma on a micro level through the cognitive behavioural approach, but it is also important to consider stigma on a macro level. This macro level approach considers two levels by which stigma is created in society: institutional policies and social structures. Pincus (1999) defines institutional policies as a stigma that comes from the prejudice of individuals in positions of power who have the ability to transform their beliefs "into law and regulations that discriminate against people with mental illness" (Corrigan, 2005, p.29). This level of stigma is exemplified when politicians devise policies that restrict the fundamental rights of individuals living with mental illness, such as voting, marriage, parenting and the right to hold public office (Corrigan, 2005).

Structural stigma is less evident than institutional stigma. Structural stigma is something that is developed historically "as a result of economic and political injustices wrought by prejudice and discrimination" (Corrigan, 2005, p.31). A common example that Pincus uses in his work is the disparity in health insurance coverage for mental illness in comparison to physical illness. Over the past number of years in the United States, benefits for physical illness have been much higher than mental illness, which can be attributed to the longstanding social structural stigma attached to mental illness.

Bruce Link et al

Dr. Bruce Link is a social epidemiologist from Columbia University. His interest in stigma began in the late 1970s and early 1980s. Link attempts to explain how stigma affects

the well-being of individuals with mental illness. A number of researchers in the social psychology field have criticized the fact that the concept of stigma is vaguely defined. Link and Phelan responded to these criticisms in their work *Conceptualizing Stigma* (2001). Link et al. contended that stigma comes into existence when four interrelated components are present. The first component occurs when people identify and label human difference. An example of identifying and labeling human difference includes labeling one's skin colour, gender and sexual preference. Labels can be considered to be substantial over-simplifications, as well as based on social selections relating to human difference that can be salient and change in accordance to time and place. This is due to the fact that 'difference' is something that is socially selected (Link et al., 2001). The second component occurs when people associate these 'differences' with undesirable characteristics. This is demonstrated through a study conducted by Link et al. in 1987, where it was found that when an individual was labeled as a 'mental patient', this person is more likely to be stereotyped as 'dangerous', resulting in the desire for social distance from the individual. The third feature of Link and Phelan's stigmatization process occurs when people that are stigmatized begin to group or differentiate between 'us' and 'them'. Therefore "the linking of the labels to undesirable attributes becomes the rationale for believing that negatively labeled persons are fundamentally different from those who don't share the label" (Link, 2001, p.370). This is exemplified when individual is labeled as a 'schizophrenic' rather than as a person living with schizophrenia. Thus, the person is different than others based upon the illness that he/she has. Finally, the last component of the stigma process occurs when the labeled individual experiences status loss and suffers discrimination based on the stigma that has been associated with the label. This feature in Link and Phelan's stigma process is unlike most definitions of stigma and is often not taken into consideration.

A study conducted by Link et al. (1987) finds that groups that are stigmatized are disadvantaged in their income, education, psychological well being, housing status, medical treatment and health. Thus, "the immediate consequence of successful negative labeling and stereotyping is a general downward placement of a person in a status hierarchy" (2001, p. 371). The research of Bruce Link et al. asserts that society is accustomed to attaching stigma as a process that occurs naturally. For instance, he contends that attaching the stigma of

dangerous to individuals living with a mental illness occurs frequently. However, there is no evidence to support that an individual with schizophrenia is any more dangerous than an individual who does not have schizophrenia.

When Link et al. (2001) discuss the importance of power as it relates to stigma, they contend that one's ability to stigmatize is dependent on social, economic and political power. The stigma process is completely reliant on access to social, economic and political power that allows for identification of differences, the construction of stereotypes, the labeling of persons as different and discrimination against them. For instance, Link et al describe how patients in a psychiatric hospital can attempt to stigmatize the staff in the hospital by labeling them as 'pill pushers'. However, since the patients are not considered to have any social, economic or political power the staff will not be stigmatized. Link et al. believes that there are varying degrees of stigmatization. That is, some groups are more stigmatized than others. It can be argued that an individual with a psychotic disorder, such as schizophrenia, suffers from greater stigmatization than an individual suffering from depression or anxiety disorder.

Link collaborates with a number of other researchers to examine the concept of stigma as it relates to mental illness. Another critical research finding associated with Link et al. is the Modified Labeling Theory, which is a part of a landmark study completed in 1982. In this study Link et al. set out to determine whether stigmatization impacts on the social support network of individuals labeled by mental health professionals as having mental illness (1989). Link et al. develop this theory to respond to numerous critics of Scheff's original Labeling Theory (1966). Modified Labeling Theory proposes that even if labels do not create mental illness these labels do have a negative impact on individuals labeled as 'mental patients'. It further contends "that stigmatization blocks mental patients when they seek to attain jobs and develop effective social support networks" (Link et al, 1991, p.302-303). Link et al. find that factors ranging from unemployment to weak social support also influence the development of mental illness. Therefore, the stigma of being labeled a 'mental patient' can have a negative impact on an individual's social situation (employment, housing, social relationships). Link et al. argue that while a person is being socialized that person is likely to develop negative conceptions of individuals labeled as 'mental patients', which impacts the

way that they treat these individuals. Thus, Link et al. finds that individuals labeled as being 'mentally ill' experience negative consequences due to this label and as a result develop coping strategies such as secrecy, withdrawal and education so that they can deal with the perceived threat of the label (Link et al, 1989).

In 1991, Link et al. published an article called the "The Effectiveness of Stigma Coping Orientation: Can Negative Consequences of Labeling be Avoided?" which discusses three possible responses to the labeling of mental illness and the stigma associated with it. Link et al. concludes that individuals living with mental illness have three different responses to the label or stigma associated with their illness. These responses include: secrecy, withdrawal and educating. Secrecy is used when an individual with mental illness chooses not to disclose his/her history of mental health issues with a potential employer, relative or partner based on a fear of rejection. Withdrawal and social avoidance happens when individuals with mental illness limit their amount of social interactions with those who know about their illness and stigmatize their condition. Lastly, individuals with mental illness respond to stigma through educating other people in an attempt to enlighten and decrease the likelihood of negative views that surrounding their illness.

Analysis and Criticism of Theoretical Perspectives of Stigma:

Over time, the perception of individuals living with a mental illness has changed. Examining the changing perspectives of mental illness and the overarching stigma associated with it has been important to determining an appropriate approach to my study of the Toronto Mental Health Court. This section will provide an overview of the strengths and weaknesses of each approach and a conclusion on the theoretical approach my study utilizes.

Throughout the history of mental illness, mental illness is very much connected to religion. During the times of Ancient Greece, madness is seen as bestowed upon a person by the gods. Later during the Renaissance era, individuals with mental illness are placed in institutions run by the church so that they could deal with the sin of being ill. The theme that arose from the examination of mental illness during this time is related to religious factors, where those who are ill are shamed by their community and considered dangerous. The stigma of shame and

label of 'dangerous' associated with mental illness continues to be an ongoing theme within the literature written about individuals living with mental illness. First mentioned in Ancient Greece, the stigma of being dangerous is also reflected on during the anti-psychiatry movement predominantly by Szasz and Scheff in the 1970s. Interestingly, it is also continued with contemporary theorists such as Bruce Link.

Also demonstrated in the historical examination of mental illness and stigma is that mental illness could be experienced by individuals from any social class. Therefore, the rich are not immune to being affected by mental illness. Examples of this are the illnesses of Charles VI of France and George III of England. Although they are royalty, they still experience stigma and are either shamed or pitied by society. Although class is not heavily discussed during the anti-psychiatry movement, it is fair to say that with the development of the post-World War II medical model for psychiatry, social class became what anti-psychiatry theorists consider to be a means of control over an individual deemed mentally disordered. Persons who deviated from the established norms (psycho-social, ethical and legal) were labeled mentally disordered and consequently institutionalized and isolated from society. Therefore, these individuals were unable to participate in the marketplace due to their imprisonment. Link et al. (1989) reflect on the issue of class further in the discussion of 'Modified Labeling Theory'. In this article Link et al. stipulate that as a result of the label of 'mental disorder' an individual experiences negative consequences. One of the consequences is the individual's inability to find and hold employment or supportive social networks, which then hinders his or her ability to experience higher socio-economic status. This is not to say that individuals from higher socio-economic status do not experience mental illness, it is just important to take into consideration that one's socio-economic status can be negatively influenced by the label and stigma of mental illness.

Laing and Szasz are criticized for their failure to consider the connection between stigmatization, gender, and mental illness. Chesler (2005) provides a feminist argument that mental illness and stigma should be considered in relation to gender. She believes that men and woman living with mental illness experience "a double standard of mental health or normality" (p.137). As such, men and women living with mental illness are viewed and

treated differently by society and by clinicians in regard to their illness. She argues that clinicians and society function upon traditional myths regarding "abnormality, sex-role stereotypes ad female inferiority" (p. 121). Further to this, she contends that throughout Laing's book *Sanity, Madness and Family* he "remains unaware of the universal and objective oppression of women and its particular relation to madness in women" (p.153).

Theorists such as Goffman, Laing, Szasz and Scheff are instrumental figures in explaining mental illness during the time of institutionalization and have continued to be influential to more contemporary writers on stigma. All of these individuals are considered important figures of the anti-psychiatry movement, a label which all of them rejected. There are similarities and differences to their perspectives. For instance, both Szasz (1961) and Goffman (1961) challenge the moral and legal issues surrounding involuntary confinement and psychiatric coercion (Szasz, 2005). As well, Szasz and Laing agree that there is no such thing as mental illness. A commonality between all five theorists is that they disagree and critique the medical model of mental illness. Unfortunately, when examining the relationship between stigma and mental illness no single theory adequately describes the relationship. None of these theories provide a comprehensive, pragmatic or theoretical model to examine and explore stigmatization when an individual suffers from a mental illness. The third edition of Scheff's book *Being Mentally Ill* (1999) discusses the limitations of other anti-psychiatry theorists such as Goffman, Laing and Szasz. He points out that similar to his beliefs, Goffman, Laing and Szasz provide an alternative perspective to understanding mental illness and psychiatry of the day. However, Scheff believes that Goffman, Laing and Szasz do not provide an actual theory to understanding and treating mental illness. He finds that Goffman's approach does not contain a theory for mental illness and that the term mental illness is only explained conceptually. Scheff considers Laing's theory to be psychologically sophisticated yet his theory behind mental illness to be even less conceptually developed than Goffman and Szasz. Lastly, he contends that Szasz has no conceptual approach to understanding mental illness since he does not believe in the term mental illness. As Szasz suggests, alternative terminology such as 'problems of living' should be used to describe what is considered by the medical community to be 'psychiatric symptoms'. Although this change in terminology may de-stigmatize those considered ill, it does not provide a concrete

framework to understanding illness. Furthermore, Scheff contends that labeling theory provides a concrete framework that no other theorist from the anti-psychiatry period was able to do.

Peter Sedgwick is a theorist who also argues against the work of Goffman, Laing and Szasz. The focus of Sedgwick's critique is that their concerns around psychiatry have actually hindered the development of better services for the mentally ill. As discussed previously, Szasz believes that physical disorders are natural and mental disorders are socially constructed. Sedgwick, on the other hand, believes that both mental and physical illnesses are social constructions (1982, p.29 as quoted in Roberts, 1996). He believes that mental illness should be considered an illness because without this recognition we are unable to make demands for mental health services that may be required in society (p.40).

Although Scheff contends that labeling theory provides a concrete framework for understanding mental illness it, too, has had a number of critics (as quoted in Link, 1982). One of the key critiques is that deviant labels are a result of an individual's mental condition rather than the result of deviant careers. Therefore, the central empirical issue surrounding labeling theory is to determine whether individuals are socially rejected due to symptomatic behavior resulting from the illness or whether they are marginalized based upon the label of 'mentally ill' (Corrigan, 2005). Other critics of labeling theory disagree on the impact which such a label has on the person. For instance, Gove (1982) states that for a "vast majority of mental patients stigma appears to be transitory and does not appear to pose a severe problem" (as quoted in Link et al. 1989, p.400). Although Scheff provides a great deal of insight regarding the negative consequences and stigmatization of individuals labeled mentally ill, his ideas are not without drawbacks. Therefore, Scheff's labeling approach does not provide a concrete framework for fully understanding the link between stigma and mental illness. As discussed above, in order to remedy the criticism associated with Scheff, modern day theorist Bruce Link et al. established the Modified Labeling Theory as well as other influential points to understanding stigma as it relates to mental illness.

Stigma- An Approach

This literature review permits us to attain a broader understanding of the different theoretical perspectives used to examine the negative consequences that stigma may have on individuals living with mental illness. As a result of this literature review, I use Bruce Link's conceptualization of stigma to examine the Toronto Mental Health Court. Link et al. argues that stigma is present through the simultaneous occurrence of four interrelated components: 1. Distinguishing and labeling differences between people. This occurs through assigning individuals to different categories. 2. Associating human difference with negative attributes. This occurs when a label is associated with an undesirable characteristic. 3. Separating 'us' from 'them', which is the belief that the negatively labeled individuals are fundamentally different from others who do not share the label. 4. Loss of social status and discrimination due to the negative label given to the individual. The four criteria from Link et al. are applied to operationalize the concept of stigma and determine whether stigma is present in the structure and functioning of the Toronto Mental Health Court. Lastly, Link contends that one's ability to stigmatize another is based upon social, political and economic powers. My examination of the Toronto Mental Health Court also takes into consideration the perspective of Link et al. on power.

Strengths and Weakness of Link et al.'s Theoretical Framework

Unlike other theories discussed in this literature review, Bruce Link et al. develop a concrete theoretical perspective for conceptualizing the concept of stigma associated to mental illness. Link et al. describe four clear criteria that are used to determine the presence of stigma in the court. Modified Labeling Theory provides a stronger argument than Scheff's original labeling theory. Modified Labeling Theory clarifies that even though mental illness is not created by simply labeling, an individual labeled as mentally ill can be negatively impacted by this label. He finds that stigma has a negative impact on an individual's self-esteem, employment status and social network (Link et al., 1989). Thus, this perspective also takes into consideration the importance of the public's perceptions as well as self-stigmatization. The Link et al. theoretical perspective regarding stigma appears to be more concrete than previous theories because they connect the relationship between labeling and power. The notion of power in Link et al.

is clear and takes into consideration the structural element of political, social and economic power. Link et al. find that a person labeled 'mentally ill' will tentatively suffer from negative social and economic consequences as they may have poor social support and difficulty in sustaining or achieving employment. It is evident that one of the core strengths of this perspective is that it takes into consideration a number of positive elements of other key theoretical points of view that aim to understand stigma as it relates to mental illness. This is what makes the Link et al. perspective the most appealing perspective to use in understanding stigma and its relationship with the Toronto Mental Health Court.

A potential critique of the Link et al perspective is the criticism of labeling theory which maintains that stigma and labeling are not major for individuals labeled as being mentally ill. Critics maintain that we live in a stigma-free world and have even gone further to contend that former mental patients enjoy "nearly total acceptance in all but the most intimate relationships" (Crocetti et al., 1974 as quoted by Link et al, 1989, p.406). Link et al. counter this claim by demonstrating that being diagnosed mentally ill negatively impacts this population. This is demonstrated by the fact that patients report trying to hide their diagnosis, withdrawing from social society and attempting to provide education concerning their illness (Link et al, 1989). It is clear that there is substantially more positive than negative evidence to support the Link et al. perspective. As such, it appears to be the most appropriate theoretical perspective to operationalizing the concept of stigma related to mental illness.

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[i] According to Greek mythology, Herakles' father Zeus was in love with Alcmene. Herakles was a product of this affair and was therefore despised by Zeus's wife Hera, who vowed to make Herakles suffer (Mythologica: A Treasury of World Myths and Legends, 2003).

[ii] These four humors include blood, yellow bile, phlegm and black bile (Zydowicz, December 1999).

Chapter 3: Methodology

In order to complete this exploratory study of the Toronto Mental Health Court, I use a qualitative research framework. The focus is on how the court encounters stigma and deals with the stigmatization of individuals living with mental illness. This research framework entails the use of both observational research and qualitative interviews with internal employees of the court and with staff members of external community agencies that advocate on behalf of the accused outside of the Mental Health Court. This methodological framework was reviewed and approved by the Carleton University Research Ethics Board prior to beginning the study.

This chapter is divided in three major sections. First, key research questions of this study are outlined. Second, I complete an overview of the observational and qualitative research techniques that are used to complete this study. Lastly, I review the strengths and limitations of this methodological framework.

Research Questions:

Utilizing a qualitative research framework of observational research, qualitative interview and literature on specialized courts, my research examines two key objectives regarding the Toronto Mental Health Court. First, I examine the structure and functioning of the Toronto Mental Health Court; and second I determine if and to what extent the court (structure) and its workers (functioning) address stigma.

By attaining a solid understanding of the organizational structure of the Toronto Mental Health Court and how it functions, I am better equipped to determine if and how the accused who appear before the Toronto Mental Health Court are stigmatized and/or if the court plays a role in reducing stigma.

1. Observational Research:

As an observer in the court, I collected in-depth descriptive information on how the court functions on a daily basis, on how professionals working in the court interact with one another and on how they interact with their clients. The opportunity to observe has been helpful in providing me insight into the state of individuals who appear before the court, and their interaction with the court and the professionals that work within it. Observing the court provided me with a foundation to understand how the mental health court functions as well as allowed me to gain valuable insight into the interview answers provided by the participants.

Observational research allows the researcher to learn things about the participants in the study that they may be unwilling or unable to discuss during their interviews (National Science Foundation, January 17, 2005). Observing the Toronto Mental Health Court is especially useful for my study, as my sample size is small and there is a possibility that some of the participants' answers provided during their interviews are in danger of being 'one-sided'. Hence, observations can play a critical part in providing researchers with a more detailed understanding of institutional and social factors that cannot be gathered in the interview process. These factors can include: information regarding the physical and social environment of the program, how the program is implemented and providing exposure to specific language used in the program. More importantly, by observing the court, I have gained greater insight into participants' non-verbal communications and take into consideration "notable nonoccurrences"[i] in the program (National Science Foundation, January 17, 2005).

Eight observational sessions varying from 2 to 3 hours in length were completed. While observing the court I took written notes on court proceedings. Although the court was open to the public, out of consideration to employees of the court, I requested permission from one of the founding judges to observe. Permission was granted and observations were completed randomly over the course of four months. After initial observations, I developed a framework to more effectively examine my research question. The framework consisted of the following categories which were applied to every case observed:

1. Demographical information of the accused (gender, age, race and possible class)
2. Charges brought against the accused
3. Reason for appearing before the mental health court
4. Results of the case (i.e., charged, bail, diversion)

Data collected during observational sessions were also completed taking into consideration the theoretical perspective of Bruce Link et al. in identifying the presence of stigma in the Toronto Mental Health Court. This theoretical framework provided me with a more structural approach to determining the presence of stigma in the nature and operation of the Mental Health Court.

2. Interviews

Sampling

In order to achieve a more detailed understanding of whether stigmatization of individuals with mental illness is present in the structure and functioning of the Mental Health Court, I conducted interviews with key players involved with the court both internally and externally. First, I interviewed key players who work within the court (i.e., lawyers, judges, psychiatrists and court support workers). Second, I interviewed staff members of advocacy agencies who support the accused once they are released into the community. These interviews enabled me to obtain an external viewpoint as well as achieve a more objective understanding of how the accused felt when they appeared before the court.

My sample was chosen through the process of snowball random sampling. I did this by sending out letters to individuals whom I had met on my previous visits to the court, such as the lawyers, judges and court workers I met while completing my observations. Upon interviewing employees of the court, I asked them for the names of other agencies they worked with that supported the accused in the community. Once I received the names of the agencies, I contacted the organization by telephone and sent a faxed letter requesting their participation in my study. When the organization received the letter, they provided the name of an individual to interview.

Although it would have been very interesting to interview accused individuals who appear before the court, there are four major drawbacks to sampling this population. First, since a number of individuals that appear before the court are in the custody of the criminal justice system, it would be very difficult to access them. Second, a number of the individuals who appear before the court are typically still manifesting symptoms of their illness and consequently, would be very difficult to interview. As such, these accused individuals are most likely not receiving any treatment for their symptoms while in custody. As a result, there is a risk to both the accused and the researcher who is conducting interviews. Third, considering the poor mental state of the accused, it would be difficult to obtain informed consent to participate in the study. Lastly, it would be very difficult to get the study passed through the ethics committee due to the risk factors associated with both the accused and the researcher.

Interviews

Conducting qualitative interviews is a method of data collection that can provide the researcher with "in-depth responses about people's experiences, perceptions, opinions, feelings and knowledge" (Patton, 2002, p.4). Interviewing allows the researcher to hear people's stories, which allow the interviewer to attain a greater understanding of participant perceptions within the system. By interviewing key players involved in the daily operations of the mental health court and advocates for those that stand before the court, I was able to get a better understanding on how the court deals with stigma.

Based on my understanding of the different interview techniques and my initial observations of the mental health court and its operations, I concluded that semi-structured interviews worked best for this research. The semi-structured interview technique, typically allows for a more in-depth interview. The interviewer asks all interviewees the same major questions in a different sequence (Hall and Hall, 1996). This process allows the interviewer to 'go with the flow' of the interview and ask follow-up questions when appropriate. The questions used during this type of interview are likely to be of an open-ended nature in order for the informant (interviewee) to be able to provide information more freely (Hall and Hall, 1996). Participants were first asked about what they understood to be the functioning and format of

the court. These answers informed my observations and gave me a clearer understanding of how the court functions. The second portion of the interviews allowed me the opportunity to obtain the views of professionals who work both inside and outside of the court, as well as their perspectives on the individuals who appear before the court.

As noted in previous chapters, the concept of stigma has been operationalized in my study by using the four interrelated criteria from Link et al. Questions asked during this portion of the interview have been constructed reflecting on these four criteria. As such, participants have been asked directly and indirectly about the presence of stigma in the court. I have used the questionnaire results to determine whether or not stigma is present in the structure and/or functioning of the court. Interviews take up to 45 minutes. The following is a list of participants involved in this study.

Participants:

I conducted a total of 12 interviews, 6 participants are employees of the court and 6 participants are employees of community agencies that work with accused who appear before the court. I, the principal researcher, transcribed all the interviews, which allowed me to have an in-depth understanding of the concept of stigma as it relates to the mental health court.

Employees of the Court	*Employees of Community Agencies*
1. Judge	1. Court Support Worker (other court)
2. Lawyer (Duty Counsel)	2. Director of Social Service Agency
3. Lawyer (Crown Attorney)	3. Psychiatrist/ Case Manager
4. Court Support Worker	4. Case Manager (Social Worker)
5. Court Support Worker	5. Case Manager (Social Worker)
6. Psychiatrist (Consulting)	6. Case Manager (Social Worker)

** To ensure confidentiality the names of the community agencies will not be disclosed in the results of this research.*

Four of the six court employees have been involved with the court since its inception in 1998. Participants interviewed in the study have significant experience working with

individuals with mental illness. Eight of the twelve participants have worked 10 years or more with individuals with mental illness. Therefore, a majority of participants have a great deal of knowledge and experience of the challenges that this population may face with regards to stigma in and outside of the Canadian criminal justice system. Also, it is interesting to note that the numbers of males and females interviewed in the study are unintentionally equal.

Appendix A contains a brief summary of the study, which was provided to participants. Appendix B contains the letter of information faxed to community organizations. Appendix C is the informed consent form signed by all participants. Lastly, appendix D contains two detailed interview guides of questions asked to court employees and staff from community organizations.

Strengths and Limitations of the Study

In preparing the methodological framework of my thesis, it has been critical to have a strong grasp of qualitative research methodology. This has been important in the way I have constructed my research design, specifically regarding how I have established my semi-structured interview guide and the way I have documented and prepared my observational data. In obtaining a solid understanding of qualitative research design, it has been critical to examine the strengths and limitations. By understanding the strengths and limitation of my research framework, I am more aware of my assumptions and I am better equipped to improve the quality of my research.

Most of the arguments that arise around qualitative research result from comparing it to quantitative research. Quantitative research relies upon the use of standardized measures in order for the informant's responses to fit into predetermined response categories (Patton, 2002). This methodology is rooted in the natural sciences and is traditionally considered to produce 'hard' data since it relies upon an analysis of numbers. In contrast to quantitative data, qualitative data is rooted in the social sciences and is considered 'soft' research since it focuses upon smaller samples and non-numerical results. The three main criticisms surrounding qualitative research are that findings are not considered

generalizable to a larger population, and that credibility and validity are considered to be weak. Since qualitative research traditionally uses smaller sample sizes that may not be randomly selected, the research can not draw broad generalizations (Hancock, 1998). Stake (1980) proposed the concept of 'naturalistic generalization', which is described as a partially intuitive process arrived at by recognizing the similarities of objects and issues in and out of context (as quoted in Myers, 2000)). He believes that naturalistic generalization ensues more commonly from a single study to one that is similar than from a single study to a population.

In addition, the credibility of qualitative research can be considered a limitation. Qualitative research depends a great deal on the skills of the researcher and her or his ability to do field research effectively (Patton, 2002). Credibility is different in qualitative research than quantitative methods, as "it asks if there is a correspondence between the way the respondents actually perceive social constructs and the researcher portrays their viewpoint" (Merten, 2005, p.254). As such, the validity of qualitative research is also considered a limitation as the instrument used to collect information are criticized for its ability to accurately measure the phenomenon that it is suppose to be measuring (Patton, 2002). For instance, results collected by the researcher may be biased since they are based on the researcher's interpretations of both the interviews and observations they complete. More specifically, observational research limitations include the complexity of organizing observations, the potential influence the researcher has on the participants being observed in unknown ways and the difficulty of interpreting the behaviors which are being observed (Merten, 2005 and Patton, 2004).

There are also a number of strengths associated with qualitative research that make it an appropriate tool for researching the Toronto Mental Health Court. This method of research has been flexible and has allowed me to modify my research design more easily than experimental designs and survey research would have allowed (Babbie, 1998). Furthermore, as some feminists have noted, qualitative research "explicitly identifies a person's understanding of the situation as something to be discovered rather than assumed" (Ezzy, 2002, p.45). Thus, qualitative research methods are beneficial in

obtaining the views of the oppressed and repressed, and those people whose voices are not typically heard. Considering that my study is geared towards examining whether stigmatization of individuals with mental illness is present in the Mental Health Court, it is an appropriate research tool to gather my data. Also, the use of a qualitative research design has yielded rich information that could not have been captured through statistical results. This has allowed me to gain a critical understanding of the roles and perspectives of individuals involved in the structure and functioning of the Toronto Mental Health Court.

By attaining a clear grasp of some of the strengths and common critiques of qualitative research design, I have been more aware of the challenges that I could have faced and am better equipped to reduce some of the challenges of using this type of research methodology. For instance, one of the methods I use to reduce the challenges to my study's credibility and internal validity is through using triangulation. Triangulation is a method that verifies the information collected by comparing different sources that have collected the information (Merten, 2005). I have done this with my research by using three methods of data collection: observations of the court; interviews with employees of the court/community agencies; and reviewing literature/documents on Mental Health courts). By comparing information from all three of these sources, I am able to minimize any biases I may have. Other methods that I used to minimize potential challenges of my research have included member checks, persistent observations and peer debriefing (Merten, 2005). For instance, I have used informal member checks by summarizing the answers an interviewee provided and asking whether the summary accurately reflected that individual's point of view.

I have completed my observations of the court over the course of four months, which allowed me to conduct persistent observations. Persistent observation is a technique which promotes credibility by allowing me to "identify those characteristics and elements in the setting that are most relevant to the question being pursued and focus on them in detail" (Lincoln and Guba, 1985, p. 304). Lastly, I have sought the opinion and advice of my thesis supervisor and thesis support group allowing for peer debriefing. The

assistance of my thesis supervisor and support group has allowed me to question my research and reduce any of my potential biases (Merten, 2005). In conclusion, reviewing literature written on qualitative research has allowed me to obtain a comprehensive outlook on the steps needed to design my exploratory study on the Toronto Mental Health Court. This process has further prepared me to determine the most beneficial analytical technique to use in interpreting the data I have collected.

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[i] A notable non-occurrence is described as "determining what is not occurring although the expectation is that it should be occurring as planned by the project team, or noting the absence of some particular activity/factor that is note worthy and would serve as added information" (National Science Foundation, January 17, 2005).

Chapter 4: The Structure and Functioning of the Toronto Mental Health Court: How the Court Works

In this chapter, I report on my research findings on the structure and functioning of the Toronto Mental Health Court. As discussed in the methodology chapter, three qualitative techniques (observational research, qualitative interviews and literature reviews) are used to develop an understanding of the structure and functioning of the Toronto Mental Health Court. In order to have a concrete understanding of the roots of the Toronto Mental Health Court, the beginning of the chapter provides an overview of the structure and functioning of other specialized drug and mental health courts across Canada and the United States of America. In this section, I highlight the similarities and differences between the Toronto Mental Health Court and other specialized courts. The last two sections of this chapter present in-depth findings on the structure of the Toronto Mental Health Court and the functioning of the Toronto Mental Health Court, which are critical when determining the presence of stigma. Stigma and the Toronto Mental Health Court will be discussed in detail in the following chapter.

Specialized Criminal Courts:

Prior to the inception of the Toronto Mental Health Court in 1998, specialized mental health and drug courts were developed in the U.S.A. The development of drug courts in both the U.S.A and in Canada has been influential in the creation of other specialized courts including mental health courts. Before describing the structure and functioning of the Toronto Mental Health Court, it is important to understand the origins of mental health courts and their precursors in other jurisdictions.

Drug Treatment Courts

American Drug Court Programs:

The development of drug court programs has been influential in the creation of mental health courts. In many respects, specialized drug court programs are considered to

be the model used in developing mental health courts in the U.S.A and Canada (Denckla and Berman, 2001). Similar to the mental health population, there is a high proportion of drug users found in the criminal justice system. Drug court programs have been used as a means of diverting this population out of the criminal justice system and into treatment facilities. Instead of incarceration, offenders are directed to long-term, court supervised drug treatment.

The first drug court was established in Dade County, Florida in 1989 (Denckla and Berman, 2001). The National Association of Drug Court Professionals reports that there are currently over 200 drug courts in the USA. Drug courts have "the responsibility to handle cases involving substance-abusing offenders through comprehensive supervision, drug testing, treatment services and immediate sanctions and incentives" (National Association of Drug Court Professionals, 2000).

Similar to mental health courts in Canada, drug court programs in the U.S.A. are non-adversarial in nature. They utilize a team of professionals to support the accused through the criminal justice system. Inter-disciplinary teams include a specialized judge, specialized prosecutor, specialized defense counsel, substance abuse counsellor, probation officers, law enforcement and correctional officials (National Association of Drug Court Professionals, 2000). Like other specialized courts, these American drug court programs are all unique, varying from jurisdiction to jurisdiction, as their structures are determined at the local level. These courts are specialized to suit the needs, strengths, circumstances and resources of each community. Initially, only those who have committed less serious offences, such as charges related to being under the influence or in possession of small amounts of drugs or under the influence of drugs were eligible for drug court programs. However, with the success of these courts, eligibility criteria have been expanded to include drug-using offenders not necessarily charged with drug-related offences (National Association of Drug Court Professional, 2000).

The National Association of Drug Court Professionals has identified some key components which are common to drug court programs. These components include:

1. Integration of substance abuse services with the justice system;
2. A non-adversarial approach;
3. Early identification of eligibility for the program;
4. Access to drug rehabilitation services in the community;
5. Monitoring abstinence and frequent drug testing;
6. A strategy that regulates the drug courts response to participants' compliance with the drug court program;
7. Ongoing judicial interaction with each participant in the program;
8. Monitoring the achievements of participants' goals and effectiveness of the program;
9. Continuing interdisciplinary education to promote planning and operations of the court; and
10. Developing partnerships with other drug courts and community based drug treatment services to increase the effectiveness of the Drug court program (National Association of Drug Court Professionals, 2000).

The effectiveness of drug court programs across the U.S.A has been evaluated and research has concluded that overall they have been successful. For example, Columbia University's National Centre on Addictions and Substance Abuse has concluded that the criminal behavior and drug use of offenders who participate in a drug court program is significantly reduced. The National Institute of Justice found that in the Dade Country Drug Court "defendants ha[ve] fewer re-arrests... compare[ed] to non-drug court defendants" (U.S. Department of Justice, 1993 as quoted in Denckle and Berman, 2001, p.7). However, a number of different studies have been critical of the drug court and its reported success. One study notes that although drug courts appear to be promising, they are understudied. As such, more information is required to provide guidance in improving the performance of drug court (Marlowe, DeMatteo and Festinger, 2003). Another study stresses the concern that the drug court model makes the assumption that all drug court clients are addicts. This is a dangerous assumption as one third of drug court participants do not have a clinically significant substance disorder. Since the drug court model is directed towards intensive treatment of substance abuse these services may be ineffective

in supporting this type of client (De Matteo, Marlowe and Festinger, 2006). Another significant criticism of drug courts is that because treatment facilities report onsite drug offences to the drug court instead of the police, and also because the prosecutor does not typically press new charges against drug court participants, drug court participants undergoing residential treatment enjoy practical immunity from additional prosecution from any new drug offences (Armstrong, 2003). In addition, another criticism of drug courts was made by Nolan (1998) who finds that "in identifying target populations, drug courts need to be sensitive to class and race bias. Unless care is taken, diversion courts may tend to disproportionately work with white and middle-class substance abusers".

Canadian Drug Treatment Courts:

In Canada, the first Drug Treatment Court was established in Toronto in December 1998 (City of Toronto, March 2005). Drug treatment courts in Canada were developed as part of the Canada Drug Strategy. [i] There are currently two drug treatment courts operating in Canada, one in Toronto and the other in Vancouver. Both courts were considered to be pilot projects, initially receiving funding from the Department of Justice's National Crime Prevention Strategy. The goal of drug treatment courts is to assist "eligible non-violent offenders in dealing with their addiction while improving their social stability" (Health Canada, 2005). As represented in its label, the drug treatment court places an emphasis on treatment rather than incarceration for certain non-violent drug offences. The focus is on addressing the root cause of drug related offences (Health Canada, 2005). It takes a specialized approach to this population by providing voluntary court-supervised treatment for people who use cocaine and other substances (City of Toronto, March 2005).

Similar to mental health courts, the structure of drug treatment courts varies from jurisdiction to jurisdiction. Although there are a number of variations among drug treatment courts there are some key components that have been identified by the United Nations. These components include:

1. Court directed treatment and rehabilitation;
2. The use of a non-adversarial approach;

3. Early identification of eligible offenders who are directed to a specialized drug court program;
4. Court directed treatment and rehabilitation are used to ensure access to drug treatment and rehabilitation resources;
5. Complete drug screens of participants in order to ensure compliance with their treatment program;
6. Ongoing judicial interaction with offenders;
7. Providing interdisciplinary education regarding substance abuse;
8. Providing case management services to assist offenders to reintegrate into the community;
9. Establishing partnerships with community based resources that provide support for this population in order to increase the effectiveness of the program (Toronto Drug Treatment Court, May 31, 2006).

The mission of the court is to assist people to remain engaged in treatment; the court "reduces relapse rates for substance use and related criminal behavior" which subsequently improves social stability (City of Toronto, March 2005, p.46).

The Toronto Drug Treatment Court has a specialized team of staff who work in the program. This team includes a judge, crown attorney, duty counsel and court staff who are specialized in the area of drug usage and treatment, as well as a representative from probation services, community/ court liaison staff, treatment staff and police liaison. The entire team has a strong understanding of substance abuse recovery. Additionally, they are committed to assisting individuals before the court to receive treatment and avoid incarceration as well as further conflict with the law (Toronto Drug Treatment Court, May 31, 2006).

In comparison to the traditional criminal court system, evaluations of the Toronto Drug Treatment Court have found it to be successful in decreasing substance abuse and criminal behaviors related to drug abuse (Toronto Drug Treatment Court, May 31, 2006). The success of drug treatment courts in Toronto and Vancouver has received

international attention and the model has been used to develop similar courts in other countries such as Jamaica (City of Toronto, March 2005). According to a report published by the United Nations, in Canada "only 11.6 % of those who complete the drug programme run into trouble again with the law" (United Nations: Office on Drug Crime, February 2005). Plans have also been made to expand the development of drug treatment courts in Canada. The Drug Treatment Court Funding Program[ii] has agreed to contribute funding to the development of four additional Drug Treatment courts in Ottawa, Edmonton, Regina and Winnipeg (Health Canada, 2005). On June 2, 2005, an announcement by the Federal Ministers of Justice and Health indicated that drug treatment courts in Ottawa, Edmonton, Regina and Winnipeg were expected to begin operations in the coming months (Department of Justice Canada, October 20, 2005).

Mental Health Courts

American Mental Health Courts

The first informal mental health court was established in Marion County, Indiana, in 1996. It was referred to as the Psychiatric Assertive Identification Referral/ Response or PAIR Program. Although it was not formally considered a mental health court, it worked in a very similar manner using pre-trial and post-booking diversion programs for offenders living with mental illness (National Centre for State Courts, 2004). In 1997, the first court referred to as a specialized Mental Health court was established in Broward County, Fort Lauderdale, Florida (Bureau of Justice Assistance, April 2000). In 2003, the Federal Bureau of Justice Assistance reported that there were more than 90 mental health courts in the U.S.A (Council of State Governments, 2003).

Mental health courts in the U.S.A do not follow a single model. Courts have different criteria for the type of mental health diagnoses and criminal offences which they accept. The courts also have different criteria for whether or not the accused has to enter a plea in order to participate in the court and how the court provides follow-up and monitors treatment. Correspondingly, the structure and functioning of American mental health courts differ from each other. The Bureau of Justice Assistance defines the Mental Health Court as a specialized court which has a dedicated docket and is different from

typical criminal court proceeding, steering away from the traditional adversarial system and towards a more therapeutic model[iii] (Council of State Governments, 2003).

A comparative study of the four originating mental health courts provides a clearer perspective on their similarities and differences (Bureau of Justice Assistance, April 2000). The four originating courts were established in Florida (1997), Alaska (1998), Washington (1999), and California (1999). All four courts focus on preventing the detention of individuals living with mental illness in the criminal justice system and diverting them back into the community through the use of support services. The similarities between these mental health courts include: having a screening and referral process which can occur either immediately or within three weeks; having an interdisciplinary team approach of dedicated justice and treatment professionals who have an expertise in mental health issues; having the court provide services to the accused on a voluntary basis; having only individuals appear before the court who demonstrate symptoms of mental illness which have contributed to their involvement with the law; and having each court provide more intensive supervision and monitoring of the accused than traditional courts where judges play a central role in the treatment and supervision of the participants in the court (Bureau of Justice Assistance, April 2000).

While the courts have many common characteristics they differ in some important respects. Key differences include: the way in which the accused are directed to the court; program eligibility requirements; the way the courts handle participants who are non-compliant with their program; and the frequency of sessions (Bureau of Justice Assistance, April 2000).

Some evaluations of mental health courts in the U.S.A have been conducted. Results of these studies find that mental health courts have a noticeably positive impact. Mental health courts not only assist participants to spend less time in custody but also keep them connected to community services which improve their quality of life. Unfortunately, there is still a need for studies that provide more long- term results (Denkla and Berman, 2001). An evaluative study completed on the Seattle Mental Health Court was published

in September 2001. Results indicate that the court has the potential to decrease the demand for detention services and to support positive outcomes for the accused and the public (Trupin et al., 2001).

The popularity of mental health courts across the U.S.A is demonstrated by the support to develop more courts across the country. In February 2001, the first juvenile mental health court was established in Santa Clara, California. Mental health courts for young offenders have also been developed in San Diego, New Jersey, Cincinnati and New York (National Centre for State Courts, 2004).

New Brunswick Mental Health Court

On November 24, 2000 the Provincial Court of New Brunswick developed another Mental Health Court in Canada. The court was initially a pilot project for the Provincial Court of New Brunswick and was meant to work with individuals with mental illness or an intellectual disability who are in conflict with the law. As part of its mandate, this Mental Health Court is committed to decreasing criminalization of individuals living with mental illness or who are intellectually disabled. The court sits much less frequently than the Toronto Mental Health Court; it is in session every second Friday.

Similar to the Toronto Mental Health Court, the New Brunswick court is also non-adversarial and takes an interdisciplinary team approach in working with this specialized population. Members include designated judge, crown, duty counsel, probation officer, psychiatrist, psychologist, mental health nurses and caregivers from the Salvation Army (Provincial Court of New Brunswick: Mental Health Court, 2003). The structure and operations of the New Brunswick Court are completely different from the Toronto Mental Health Court. The court procedure is comprised of two different phases: the admissions phase and the program phase. The admissions phase has four different sections to it: presentation, eligibility, compliance and acceptance to the program. Initially, individuals are referred from the mainstream criminal court stream if it is learned that the accused may have either a mental illness or an intellectual disability. At

the presentation stage, some accused are assessed to determine whether they are fit to stand trial or whether they are criminally responsible. At this stage, the duty counsel of the Mental Health Court provides the accused with an explanation about the program. The judge, with the support of the mental health court team, determines eligibility to the program. It is also at this stage that the crown determines how to proceed with charges against the accused, and whether charges can be withdrawn or a recommendation will be made for a non-custodial sentence upon completion of the program. The program requires that the accused have a mental illness, that the alleged offence(s) be related to their mental health status, that the accused accept responsibility for their charges and that the accused is deemed fit to stand trial. The accused is sent back to the mainstream criminal justice stream if he or she is considered ineligible for the program.

The third stage of the admission process is compliance. At this stage, both the court and the accused determine whether the accused is ready to be monitored and comply with the program. The last stage of the admission process is formal acceptance to the program. This process entails that the accused apply in writing to the program before going to court. The formal application involves the accused agreeing that they have a psychiatric illness, reporting the medication that they are taking and consenting to being followed by the mental health court program. Once the accused has completed the first phase they then enter the second phase. The program can take anywhere from seven months to a year.

The second phase of the mental health court approach is the program itself. It is at this phase of the process that accused are placed under conditions that have been specifically designed for them. Conditions are often developed in the earlier stage of the process. These conditions relate to the accused persons and their living arrangement, restrictions on the use of alcohol or illicit drugs, curfews etc. The court then monitors compliance to the conditions of the program where the accused is mandated to court every two weeks. Upon graduating from this phase of the program, charges can either be withdrawn or a non-custodial sentence be put in place.

An evaluation of the New Brunswick court was completed from November 2000 to November 2004. In this time, 94 cases appeared before the Mental Health Court. Results from this evaluation indicate that the program appears to be successful as it found high retention of the accused in the program and a low-recidivism rate of individuals who graduated from the program (Provincial Court of New Brunswick: Mental Health Court, 2003). In sum, the court appears to be achieving its goal of reducing the criminalization of individuals with mental illness or individuals who are intellectually disabled. The evaluation report indicates that a majority of accused that appear before the court have major mental illnesses. It is important to note that the evaluation did not specify the exact numbers of individuals with intellectual disability that they have serviced.

Unlike the Toronto Mental Health Court, fitness to stand trial is not the primary concern of this mental health court since it requires the accused to be 'fit' in order to be eligible to take part in the program. The program places an emphasis on treating the accused and diverting them out of the criminal justice system. The admission process to the program appears to be quite rigorous and more time consuming. An individual deemed unfit is not even considered by the court since their program focuses on compliance with a program. The program as a whole appears similar to the diversion program of the Toronto Mental Health Court, since the program concentrates on diverting accused out of the criminal justice system and places conditions on them to complete program.

According to the Bureau of Justice Assistance, problem-solving courts seek to "address the problems 'root causes' that contribute to criminal involvement of persons in the justice population" (April 2000, p. vii). The structure and functioning of the Toronto Mental Health Court is different from both the American and New Brunswick model. However, the underlying goal of all three of these courts is to provide a specialized, supportive service for individuals living with mental health issues who face the criminal justice system.

The Structure of the Toronto Mental Health Court

As discussed in the methodology chapter, qualitative research was conducted through observations of court proceedings and interviews with employees who work within the Mental Health Court and employees of community agencies who work with the accused appearing before the court. This section provides detailed research findings on the structure of the Toronto Mental Health Court.

The Role of Court Employees:

The following explains the roles that employees of the mental health court play:

Designated Judge:

According to my observations and participants responses, three specialized judges work within the Mental Health court. Judges are well versed in the mental health aspect of the criminal code and are specialized in working with individuals with mental illness.

Designated Crown Attorney:

The Attorney General of Ontario employs the crown attorney; the crown attorney role is to prosecute the accused that appear before the Mental Health court. The crown attorney is also responsible for the administration of the mental health diversion program. The crown attorney works with a number of different actors in the court and outside of the court to complete release planning as well as diversion for accused deemed appropriate. Based on observations completed for this study, there are two designated crown attorneys working in the Mental Health Court.

Designated Duty Counsel:

The role of the duty counsel is to supply support to accused who have no legal representation. They are typically the first to be in contact with the accused. Their role is to advocate on behalf of the accused, to try to ensure that the rights of the accused are protected and to assist them with entering a plea (bail hearing or guilty plea). According to observations completed in this study, there are three designated duty counsel for the court. They are employed by Legal Aid Ontario.

Mental Health Court Support Workers:

Community Resource Connection of Toronto (CRCT) employs Court support workers who work in the Mental Health court. They receive referrals from a variety of sources, which include the: crown attorney, duty counsel, defense counsel and external community agencies. Mental Health Court Support Services also have an open door policy for the general public, which allows the accused and their family to receive support. The court support program consists of release planning by making referrals for individuals leaving custody or who require additional support in the criminal justice system. One of the key roles of mental health court support workers is providing case management services for diversion of the accused. Court support workers work very closely with the crown in the case of the diversion program.

Consulting Psychiatrist:

According to my observations there are three different psychiatrists who staff the Toronto court. The Centre for Addictions and Mental Health (CAMH) employs all three psychiatrists. CAMH is a mental health facility located in the Toronto downtown. The psychiatrist typically sees the accused that have been placed on a form 48[iv] to complete a fitness assessment. The accused is interviewed by a psychiatrist to determine the presence or absence of illness; the psychiatrist provides the court with an opinion as to whether the accused is fit to stand trial. A psychiatrist is available five days a week to ensure that fitness assessments are done in a timely fashion and that the accused are not spending too much time in custody.

Role of Community Workers:

The primary role which workers in the community play with the accused is that of support once someone is released from jail. Case managers from a variety of agencies in the Greater Toronto Area work with the accused that appear before the court. Organizations associated with working with individuals in conflict with the law include: The Elizabeth Fry Society, Canadian Mental Health Association, Assertive Community

Treatment Teams, The Toronto Bail Program and other Mental Health Service Agencies which preferred not to be specified.

I interviewed two different groups of community workers in my study. One group plays a direct role with accused that appear before the court and another group does not. Four participants reported that they played a more direct role with accused who appear before the court by providing voluntary case management and supervision services. These community services most often received referrals from attorneys who work within the court (crown, duty and defense counsel). The other two participants indicated that they did not play a direct role with accused who appear before the court, but had worked with the manager of mental health court case management services in regards to service provisions such as applying for funding or suggesting potential assistance their agency could provide.

Interestingly, it was extremely difficult to access employees of external community agencies for interviews. In several instances, agencies with staff involved in the mental health court stated that they were not sufficiently involved and did not feel that their staff had enough knowledge to contribute to the study. Obtaining interview subjects required casting the net more widely than was originally believed to be necessary.

The Organizational Structure of the Toronto Mental Health Court:

Results have been compiled by conducting a literature review on documents written on the court, and collecting information from observational sessions and responses of participants. From my research, I created a flow chart on how accused are sent to the Mental Health Court and how the court operates when dealing with them. This flow chart structure is based upon the mainstream criminal court model and is found on the following page as Figure 1.1. Creating this flow chart has allowed me to develop a concrete understanding of the different cases that the mental health court deals with as well as to identify the different alternatives accused individuals face (i.e., incarceration, diversion, bail, mental health system for further treatment) when appearing before the court.

Figure 1.1: Structure of the Toronto Mental Health Court

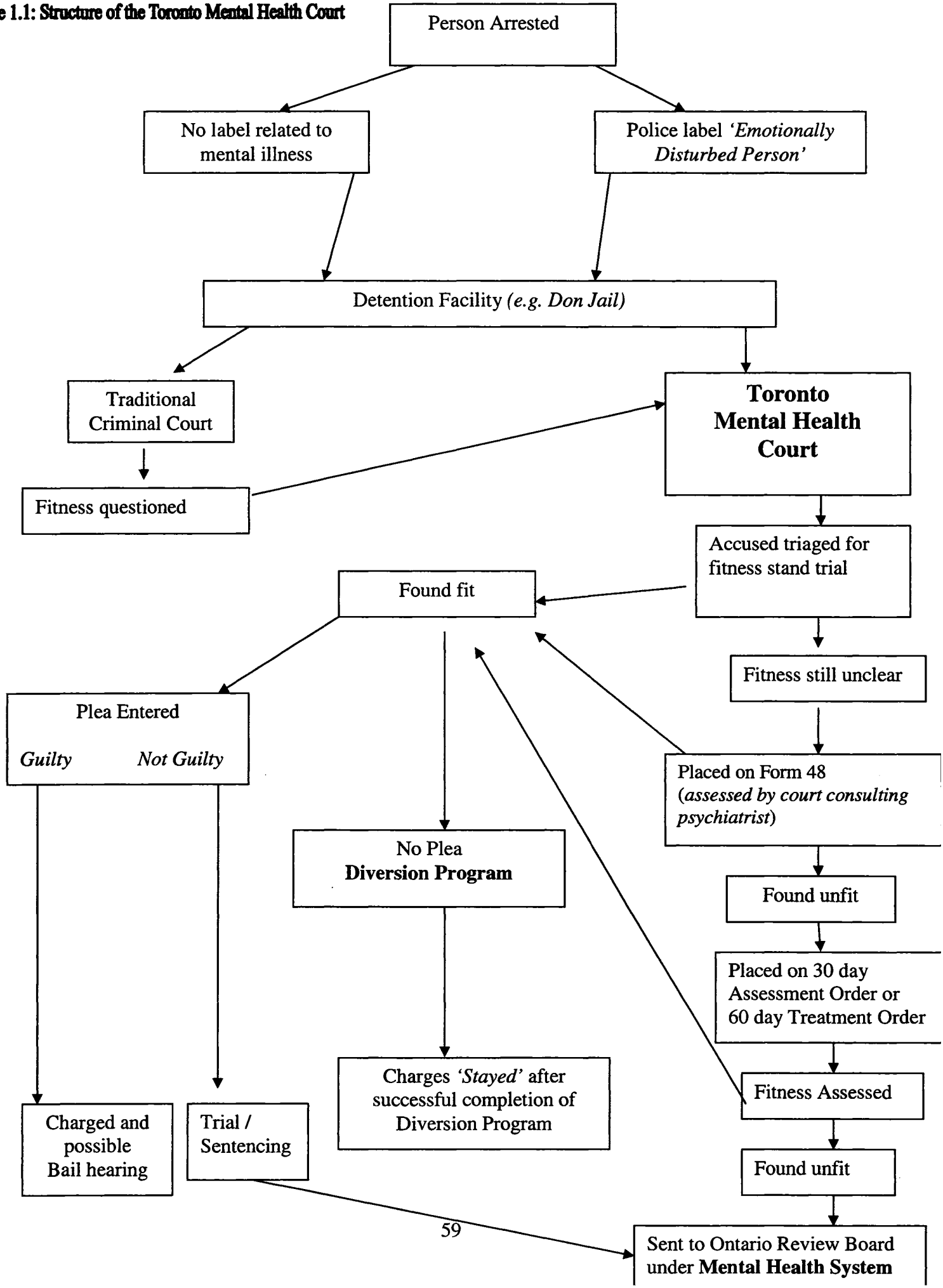

Figure 1.1: Structure of the Toronto Mental Health Court

As demonstrated in Figure 1.1 there are two ways to which an accused appears before the court. First, an accused person can also be directly sent to the Mental Health Court when (s)he is labeled at the time of arrest to be an *'emotionally disturbed person' (EDP) and* therefore in need of additional support. Police officers are the individuals with the power of deeming an accused as an *EDP.* If an accused is not designated an *EDP* (s)he is processed through the mainstream criminal justice stream. Second, accused individuals appearing before the court are sent from various courthouses in the Toronto area as well as other court rooms inside old city hall. An accused is sent to the Mental Health Court (also known as 102 court) when there is a concern with respect to his or her fitness to stand trial.

As such, once an accused appears before the court the primary concern is to assess their fitness to stand trial. If the accused is found fit there a few options which may then take place. These options include: having their charges dealt with in the Mental Health Court; the crown attorney offering a no plea diversion; or the accused being forwarded back to the mainstream criminal court stream to face their charges. If the accused is assessed and determined to be unfit or requiring additional clarification of fitness, the accused continues to go through the Mental Health Court structure. Further information, discussing the Mental Health Court's no plea diversion program and how the court support accused assess to be unfit are discussed later in this chapter.

Who Appears before the Mental Health Court? :

During my 10 sessions in court, I had the opportunity to observe 37 cases. A large majority of the cases involved a male being accused – 27 men to 10 women. A majority of the accused of both genders fit either the 21 to 35 age category or 35 to 45 age category. In terms of race, in most of the cases observed the majority of the accused were identified as Caucasian: 18 out of 27 men and 6 of 10 women were Caucasian.

Figure 1.2: Observational Results – Examining Race and Gender

Race	Male	Female	Total
Caucasian	18	6	24
Black	6	3	9
Other (e.g., Asian, East Indian and other visible minority groups)	3	1	4
Total	27	10	37

** Race was not determined using the same criteria used by Statistics Canada. Racial data was collected through observational research. Accused were not asked their racial background, rather a determination of race was made at the discretion of the researcher.*

Figure 1.2 demonstrates that 24 of the 37 cases observed involved Caucasian offenders. This is interesting as it differs from the mainstream criminal justice system. Although most individuals incarcerated in Canada are Caucasian, there is an over-representation of both Aboriginal and Black offenders in the Canadian criminal justice system. A 2004 study conducted by the Correctional Service of Canada reported that although Black people made up 2 percent of the Canadian population, they represented 6 percent of the offenders in federal correctional facilities. This disparity is even larger for Aboriginal people as they represent 3 percent of the adult population and 18 percent of the inmates in Canadian correctional facilities (Trevethan and Rastin, June 2004). Over-representation of Black and Aboriginal peoples has not been observed to occur in the Toronto Mental Health Court. In fact, no Aboriginals were observed as an accused in the Toronto Mental Health Court. This is consistent with an evaluative study completed in the Seattle Mental Health court, which reported that 56.9 percent of participants who appeared before the court were Caucasian (Trupin et al. 2001). In addition, not unlike the mainstream Canadian criminal justice system, there was a larger proportion of male accused compared to female accused.

In an attempt to get a clearer conception of issues regarding race, class and gender, two cases scenarios were posed to participants. The participants were asked questions regarding treatment of accused in the court and potential outcomes of court proceedings. These scenarios were presented to determine whether a person's age, race and class would impact their experience in the Toronto Mental Health Court. Although all of the participants answered these questions, a majority of participants were dismissive of the demographic information provided in the scenario and concentrated on the charges of the accused in order to predict outcomes of the scenario. Most of the participants reported that both the case scenarios of the 35 year old gentleman and 18 year old woman were typical cases seen in the Toronto Mental Health Court. A majority of participants felt that outcomes of proceedings and the potential for diversion were the same for both case scenarios. A common response given by participants was *"the outcomes of this case would be similar to other case scenario"* or *"the process would happen just like it did in the other case scenario"*. Other participants felt that the outcomes of the case were based on the charges of the accused stating *"what is his charge... it depends on his criminal record"* or *"depending on the level of harassment the Crown would need to determine whether or not diversion would be appropriate"*. Participants' responses concentrated on providing information on the courts' functioning rather than specified experience of potential accused.

Only two participants considered demographics of the accused in the case scenarios. One participant felt that the case of the gentleman was an appropriate scenario since he was *"the typical age of an accused... and that men are probably disproportionately represented in the criminal justice system and that mentally ill men are the ones the end up in our system"*. Only one participant felt that there may be different outcomes in court proceedings between case scenarios as this participant felt that the accused woman may be more likely to receive bail. This participant stated that *"there was still hope because she is younger... she is only 18 year old, she will likely have more connections to social supports"*. This response is the only recognition that the accused who appear before the Toronto Mental Health Court may receive differential treatment based on structural differences. This is an interesting response since research studies have been conducted on

the prevalence of racism in the Ontario Criminal Justice System. Specifically, the Report of the Commission on Systemic Racism in the Ontario Criminal Justice System (1995) confirmed the perception of racialized groups as not being treated equally by criminal justice institutions and that these findings are not limited to the police. As such, participants' responses contradict research findings of systemic racism in the criminal justice system. The majority of participants felt that the accused in both case scenarios would be treated the same.

Through these findings, further questions surrounding the population that the Mental Health Court serves are raised, including whether race plays a role in being transferred to the court for an assessment? Is race a factor in the type of offences committed by accused? Why is there a larger Caucasian population among the accused appearing before the Mental Health Court? Lastly, does gender play a role in those sent to the Mental Health Court? Is the Court more sympathetic to women regardless of race/ethnicity? Such questions demonstrate the extent to which further research is required to understand the issues of race and class as they relate to the type of accused who appear before the Toronto Mental Health Court.

Figure 1.3: Observational Results – Examining Socio-economic Status of Accused

Class	**Male**	**Female**	Total
Upper	2	0	2
Middle	5	0	5
Lower	10	7	17
Unknown	10	3	13
Total			37

It was difficult to determine the socio-economic status of the accused when appearing before the court. The socio-economic status of accused that appear before the court was determined at my own discretion as the principal researcher during court observations. Indicators of class were completed through examining the appearance of the accused and information provided by the court regarding their financial situation. Evidence of an

individual's financial situation included housing, receipt of income from the Ontario disability support program, as well as information regarding an individual's employment status. Because information regarding the financial situation of the accused was not always available, some individuals were classified as unknown.

It is not surprising to note that a large number of those who appeared before the court came from a lower socio-economic background. These results are similar to those found in the mainstream Canadian criminal justice system. For instance, the Counsel of Elizabeth Fry Societies describes women who come into conflict with the law as "typically young (average age is about 30), lone parents, and poor. The average woman in prison has less than a grade nine education and was unemployed upon arrest (Finn et al., 1999)" (Council of Elizabeth Fry Societies of Ontario, December 7, 2005). The John Howard Society of Ontario reports that there is evidence that demonstrates that an individual's socio-economic status is related to their involvement in criminal activity. Such factors include the income disparity between individuals. In 1993, Statistics Canada reported that the socio-demographic characteristic that most strongly correlated to crime was male unemployment rates (John Howard Society of Ontario, 1999).

Reasons for Appearing before the Court:

Participants tended to agree that accused individuals appeared before the court because of concerns regarding fitness and possible diversion of charges due to the possibility of mental illness. It is interesting to note that participants with a social work educational background tended to link the appearance of the accused before the court to social circumstances such as poverty, lack of social support, lack of long-term case management services in the community and difficulties accessing the mental health system. Non-social worker participants, particularly those who work in the criminal justice system, believe that the primary reason for which individuals appear before the court is to determine fitness and possible diversion of charges. Figure 1.4 provides results of observational sessions.

Figure 1.4: Reasons for Appearing before the Mental Health Court

Reasons for Appearing	Male	Female	Total
Fitness Assessment	21	6	27
History of Mental Illness	3	3	6
Diversion	2	0	2
Unknown	1	1	2

Figure 1.4 demonstrates that a majority of the cases observed in the court were fitness assessment hearings and further fitness assessments by a psychiatrist. Most of these cases resulted in a treatment order sending the accused either to a mental health facility or to a bail hearing. When an accused person was not able to be assessed on the first appearance, some of the accused were remanded back to a detention facility. If the accused was remanded to custody to wait, the presiding judge most often asked for the accused to be placed in the medical wing of the detention facility to wait for their proceedings. Although the mental health court has an extensive diversion program, a diversion proceeding only accounted for 2 of the 37 cases observed.

Charges that were most commonly observed in the Mental Health Court were breach of probation and assault. Unfortunately since a number of cases were only in court for a brief period of time, charges were seldom identified.

The Structure:

The structure of the court is organized similar to any other criminal court, in that it has a judge, duty counsel, crown attorney, court reporter etc. However, the Mental Health Court has designated judges, duty counsels, crown attorneys, court officers and clerks who are familiar with and specialized in working with individuals with mental illness. Unlike other criminal courts, the Mental Health Court has on-site mental health

support services and psychiatrists. The consulting psychiatrist is provided by the Centre for Addictions and Mental Health and is available on-site every afternoon to complete a fitness assessment and provide expert opinion as to whether the accused is fit to stand trial. These assessments are completed in the office space directly adjacent to the court. Also located in this office space is a team of mental health court support workers employed by CRCT. Mental health court support workers are available to provide support with release planning (housing, follow-up), to accompany the accused to court and to provide case management by facilitating diversion for the eligible accused. Participants indicated that accused individuals are transferred to the Mental Health court when their fitness to stand trial is questioned. If they are considered fit, they are sent back to the originating court. Accused are sent from all local detention centres and jails across the Greater Toronto Area, including the Don Jail (now known as the Toronto Jail), Maple Hurst Correctional Complex, Vanier Centre for Women and Toronto East and West Detention Centre (Ministry of Community Safety and Correctional Services, October 27, 2003).

The Purpose:

Participants agreed on three primary purposes of the Toronto Mental Health Court. Six of the twelve participants felt that the primary purpose the court served was to complete fitness assessments more expeditiously and more efficiently than is done in the normal criminal court stream. Second, four of the twelve participants felt that the purpose of the court was to reduce the number of re-offenders in the criminal justice system by improving access to support and diversion. Lastly and most prominently, ten of the twelve participants felt that the purpose of the court was to provide specialized support for the special population of individuals with mental illness by providing assistance and liaising between the accused and the support services available in the mental health system. Documentation on the Toronto Mental Health Court supports participants' responses by indicating that the primary aim of the court is to place accused living with mental illness back into the mental health system and to reduce the amount of criminalization they experience (Schneider, 1998).

Participants agreed that there were two major problems that the court attempts to solve. First, seven of the twelve participants believed that the court was designed to divert individuals with mental illness out of the criminal justice system and into the mental health system where they could access further support and treatment. One participant stated,

> *"we are trying to get them out of the criminal justice system with the support of the crown attorney and the duty counsel... we are trying to send people to the right programs in the community in order for them to avoid these situations... the court tries to do this instead of punishing someone for their mental illness"*

Another participant stated,

> *"the court is less adversarial than other court proceedings...we are focused towards getting the accused back on the rails and out of the criminal justice system"*

Secondly, participants agreed that the court tries to improve the process of completing fitness assessments and supporting individuals with mental illness through the criminal justice system.

Strengths and Limitation of the Court Structure:

Strengths:

Participants agreed that the advantage of the mental health court is that it is designed to be much less adversarial than the typical Canadian criminal court. That is, court personnel worked more collaboratively to support the special needs of the accused. It was also considered advantageous to have dedicated personnel who work in the mental health court. One case manager who was familiar with how other courts are structured indicated that having dedicated personnel (judges, crown, duty counsel and court support workers) working with this population increased the efficiency of the court. Court personnel are much more familiar with conducting fitness assessments than is the staff in

the mainstream criminal courts. In addition, dedicated personnel were also considered to be more sensitive and empathetic to the accused who appear before the court. Lastly, the availability of court support workers to assist the accused is also considered to be a strength.

Limitations:

Some participants felt that there were three major limitations that the court faces. The first limitation is a gap in the legal system between an individual's fitness to stand trial and an individual suffering from a mental illness. Participants described experiences where the accused met the legal criteria of being fit to stand trial but they still demonstrated symptoms of a severe mental illness. This was considered a barrier since fit accused suffering from a mental illness do not meet the criteria of having proceedings dealt with in the mental health court and could not be connected to the mental health system for additional support. A participant stated *"I see a lot of clients fall between the cracks and do not get the help they need... because they are 'fit'...I think that is a major gap"*. Another participant reflected that the consequence of this limitation is that accused who are considered fit and suffer from a mental illness are at risk of being further criminalized in the criminal justice system. This participant believes that justices of the peace and crown attorneys in the mainstream criminal court system may not have the same level of understanding about mental illness, which would likely mean that they err on the side of caution and keep an accused in detention due to their behavior. This participant describes the result as *"making criminals out of an individual suffering from mental illness"*.

Participants also felt that another limitation of the Mental Health court is the lack of resources and social support available to accused who were eligible for bail or probation. One participant stressed the difficulty in accessing assessment beds in the mental health system stating that *"we have a crisis now at the Centre for Addictions and Mental Health with a lack of hospital beds for our assessment". The consequence is that* some of the accused are obligated to wait for assessment in detention.

Another participant stated,

> *"Resources in the community, it is not the court itself. It is the places where we can put people who are released on bail or probation. For example we want to make sure that they have a spot at a group home and can get the proper supervision. If there is no supervision than we have trouble putting individuals out on bail, this is a real shortage with resources and services for mental health"*

Other limitations mentioned by participants include the lack of enough mental health courts with the same structure in the area to service the demand from this population. In addition, participants tended to agree that there are wait times associated with transferring an accused through the system that result in delays for case managers following an individual that has been placed on bail. Participants believe that these delays are the result of miscommunication between internal actors of the court and community services. Another limitation is the risk of compromise of objectivity since Mental Health Court judges play a role of advocate for the accused while also determining guilt and appropriate sentencing. Not unlike other courts in the criminal justice system, the Mental Health Court is considered to have a lack of cultural sensitivity and lack of consideration for other advocacy groups in determining appropriate sentencing for the accused. This accusation may be related to the fact that most of the individuals who work in the court are Caucasian, and there are no culturally sensitive services directly connected to the court. Lastly, participants agreed that a barrier the court faces is lack of resources and long term case management services where the court can refer accused.

The Process:

As discussed above and demonstrated in figure 1.1, accused individuals have two different avenues of access to the Mental Health Court. The accused can either be forwarded directly to the court from the local detention facilities, based on being considered by the arresting officer to be *EDP*, or they can be sent to the court from the regular criminal court stream after first appearance. This is done if the fitness to stand trial of the accused is questioned by the presiding judge, crown attorney or defense counsel.

Once the case file accused is forwarded to the Mental Health Court, the duty counsel, the crown attorney and the presiding judge of the court review their case in order to determine their fitness. If the accused is deemed fit at this point in the proceeding, they are returned to the originating court and normal criminal justice stream. If the fitness of the accused is still in question, the judge places the accused on a form 48 assessment order and directs the Mental Health Court's consulting psychiatrist assess the accused. The Mental Health Court's consulting psychiatrist is present every afternoon in the court to complete fitness assessments.

Fitness to Stand Trail

According to participants, fitness assessments are completed in a two-part process. First the psychiatrist assesses the fitness of the accused to determine whether they do or do not suffer from an illness. The consulting psychiatrist attempts to clarify the diagnosis by examining whether the accused has a history of treatment and whether they are taking medication. Secondly, the consulting psychiatrist determines fitness by completing a fitness assessment. This test entails determining fitness by assessing whether the accused knows what the charges are, can reasonably describe the roles and functions of people in the court (judge, crown, court officer etc.), can understand what pleas are available to him or her, is able to understand the consequences of the proceedings and, lastly, is able to communicate with his or her lawyer in order to participate in the proceedings.

The purpose of determining fitness is to guard against the inequity of trying and convicting accused individuals who lack the fundamental understanding of the proceedings that can adversely affect them. Determining fitness is a method used to maintain fairness in criminal proceedings (Zapf et al. 2001). According to section 2 of the *Canadian Criminal Code,* an accused "unfit to stand trial "is considered unable on account of mental disorder to conduct a defense at any stage of the proceeding before a verdict is rendered or to instruct counsel to do so, specifically they are unable to: (a) understand the nature or object of the proceedings, (b) understand the possible consequences of the proceedings or (c) communicate with counsel. Assessments are

completed in a semi-structured interview fashion. Unlike other Canadian criminal courts, the assessment of fitness is completed by an on-site consulting psychiatrist, which is done much more expeditiously than transferring the accused to a local mental health facility for assessment.

Once an assessment is completed, the consulting psychiatrist testifies before the court in order to provide a determination of the fitness of the accused. If the accused is considered to be fit, he or she is transferred back to the originating court, which is typically back to the mainstream criminal court system. If the consulting psychiatrist determines that the accused is unfit they typically testify that the individual is suffering from a mental illness and that they require a 30 day assessment order[v] or 60 day treatment order[vi] in order to become fit. The unfit accused is sent forthwith to a mental health facility under one of these orders; "forthwith" means within a five day period. Once a fitness hearing is completed and the accused is found fit, the accused then has the opportunity to put in a guilty plea or return back to the originating court to face the charges. Once a guilty plea is entered by the accused, the accused is charged and, where applicable, a bail hearing is held.

Overview of Court Proceedings

Once a person is found fit to stand trial, the accused can proceed through the criminal justice system. The process goes as follows: Bail Hearing, Crown Pre-Trial Meeting (possible diversion of charges and resolution before trial), Trial and Sentencing.

Bail Hearing

An individual that is found fit is normally transferred back to the originating court. However, participants agreed that if the accused would like to have their charges dealt with in a more expeditious manner, a guilty plea and bail hearing can be held in the Mental Health Court. The bail hearings that take place in the Mental Health Court occur in the same manner as they would in the mainstream criminal court. However, if the individual is identified as requiring additional support and needs access to support mental health services, clothing or a bed in a local shelter the support of mental health court

workers is often solicited. In addition, if the accused does not have a surety [vii] that is willing to supervise them while on bail, the Toronto Bail Program is also able to supervise these individuals. They have a specialized case manger that works specifically with the Mental Health Court to support individuals eligible for bail.

Crown Pre-Trial Meeting and Mental Health Diversion

At this point in the process, charges have already been laid. The crown attorney is responsible for the functioning of the diversion program in the Mental Health Court. It is at the discretion of the crown attorney to determine whether the accused is eligible for the diversion program. The program functions in collaboration with court support workers from Community Resource Connections of Toronto (CRCT) who provide case management services for the individual. Diversion is determined on a case by case basis and at the discretion of the crown attorney of the Mental Health Court. The diversion program is a voluntary program. Diversion is only considered for the accused who commit relatively minor offences which generally are non-violent. These offences include: shoplifting, breach of probation, public nuisance and minor assaults (Schizophrenia Society of Canada, February 18, 2005). According to employees of the court, diversion can take anywhere from six months to a year to complete. Once diversion is completed, the crown attorney can either enter a stay of proceeding or withdraw the charges. In most cases charges are stayed,[viii] whereas in a majority of jurisdictions charges can only be withdrawn after a significant period of compliance. This type of diversion program is considered no-plea diversion since the individual is charged but is not required to enter a guilty plea (Schizophrenia Society of Canada, February 18, 2005). Diversion can take place at two points in time, either on the first appearance of the accused or once he or she is found fit to stand trial.

According to a participant, in 1994 the "Diversion of Mentally Disordered Accused" was developed as a formal part of the Crown's Policy Manual. However, diversion has been part of the criminal process more informally for a number of years on an ad hoc basis with the collaboration of both the Crown attorney and defense counsel. Diversion can occur at any stage of the prosecution, but it is generally more advantageous for it to be

completed earlier in the process. Currently, the Crown policy surrounding diversion of individuals who appear before the Mental Health court is stipulated by the Crown Policy for Diversion of Mentally Disordered/ Developmentally Disordered Accused (Ministry of the Attorney General of Ontario, March 21, 2005).

Trial and Sentencing

An accused has the opportunity to go straight to sentencing if they would like to enter a guilty plea. If the accused chooses to enter a guilty plea while before the Mental Health Court, it can be processed and the individual is sentenced. If the individual chooses to go forth with a trial, proceedings are typically forwarded to the originating court. The Toronto Mental Health Court has rarely been the setting for a trial (Gordon, Winter 2005).

Once the accused reaches the point of entering a plea he or she can choose to plead not guilty and go to trial and sentencing. It is at this point in time that the accused can also be sent to the mental health system by being found "Not Criminally Responsible" (NCR). It is a finding that an accused is NCR for the offence if their mental illness prevents them from appreciating the nature of their actions or comprehending that their actions were wrong. A finding of NCR means that the court believes that the accused committed the offence, however, due to mental illness the accused is not held responsible under the legal system. An accused can only be considered NCR in reference to his or her mental state at the time of the offence. As such, not all individuals living with a mental illness and accused of crime are made NCR. When individuals are found NCR they are the responsibility of the Ontario Review Board.

It is important to note that violent offenders who are living with a mental illness are not eligible candidates for the services of the Toronto Mental Health Court. As such, they are still processed through the mainstream criminal court system (Gordon, Winter 2005).

The Functioning of the Mental Health Court:

Participants agreed that there is no such thing as a typical day in the mental health court. They reported that their caseloads could be quite unpredictable and that a key part

in all of their roles was co-ordination. One participant stated, *"there is no way that we can forecast what our work and caseload is going to look like"*. Findings show that individuals who work both inside and outside of the court co-ordinate information differently. For instance, when the psychiatrist completes a fitness assessment of an accused they attempt to get as complete a picture as possible within a short period of time. They do this by gathering information (disclosures) from court proceedings, gathering collateral information from present family and friends, determining whether accused have been treated in the past and contacting former doctors to retrieve additional information. This is all done in the best interest of the accused.

Advocacy is central to the functioning of the court. All of the participants in the study discussed their role as advocates for the accused. The role of advocacy is best outlined by one of the participants who described the court as a *"very warm atmosphere, you walk in and people are talking about the best thing that we can do for the client"*. This demonstrates how the court is a problem-solving arena with a non-adversarial approach.

When describing the daily functioning of the court, participants who work both internally and externally were familiar with the collaborative processes of the court. This familiarity was evident specifically when describing the daily activities of the court, the role of the duty counsel, the role of the crown and the role of consulting psychiatrist. Participants also emphasized the importance of internal and external consultation when assisting an accused at all stages of the process. This diversion program demonstrates the court's collaborative process. The crown is responsible for initiating the diversion process and works in consultation with a number of different people, including duty counsel or defense counsel, mental health court workers, the Toronto bail program and even case management services who support the accused in the community.

Participants described the court as more compassionate knowing that an accused may be suffering from a mental illness. One participant described a situation where an accused who was scheduled to appear in court for 10 a.m. did not appear before the court as scheduled. In these cases the judge typically will wait until the end of the day, rather than

at 10:15 a.m., to issue a bench warrant so that the accused has time to get to the court. The employee described that in some cases they have an idea of the shelter or the street corner where the accused has been staying and, in one instance, described that the court employee found the individual and reminded him that he was scheduled to appear in court. The accused then followed the employee back to court. In such situations, the accused avoided additional charges due to the support given and the understanding that the court employees had about mental illness. In other cases where employees of the court are unsure where the accused may be, the court is known to give discretionary warrants which allow the accused a couple of days to appear before court before being charged further. Although participants consider this a compassionate function of the court, another participant described that some defense counsel from the criminal court stream try to transfer their clients down to 102 court when there is not even a fitness issue, because 102 is known to be compassionate, and subsequently more lenient.

Another important aspect of the court's functioning is how frequently those inside and outside of the court structure work with community agencies outside of the court structure in support of the accused. A majority of participants indicated that they work with people outside of the court structure daily and, at a minimum, once a week. Some participants indicated that they work with these agencies in order to access services such as case management for the accused. Other participants indicated that they worked with agencies outside of the Mental Health Court structure regularly as they are an important part of supporting this individual in the community. Also worth noting are the challenges that are faced in accessing services for this special population. There are a lack of specialized resources for supporting an individual living with a mental illness and who is also in conflict with the law. Although participants attempt to access services for this clientele, it can be difficult considering a number of mental health services refuse to work with an individual who is in conflict with the law and has had legal problems in the past. Thus, there is a stigma that exists in the mental health system against those individuals who are also in conflict with the law.

Rewards and Challenges

Participants in the study were asked to reflect on the rewards and challenges of working in the Mental Health Court. Learning the rewards and challenges that the participants face working in and with the court provides a greater understanding about how the court functions.

Challenges

Some participants believed that the court places unrealistic expectations on their services and that when working they experience a great deal of wait time due to inefficient communication with court personnel. For instance, community services are asked to provide case management services to the accused immediately upon their release and this can be very unrealistic. Participants felt that the court does not consider that a majority of case management services are voluntary and that individuals with no insight that they suffer from an illness may refuse assistance. Therefore, community services can not be made a requirement of the bail conditions of an accused. Another challenge, which participants reflect on, is the lack of physical space within the Mental Health Court for community organizations to complete assessments. Participants reported that there is only one interview room available in the Mental Health Court, which is typically utilized by court personnel. They found this challenging since there is no specialized space for community organizations to complete assessments of accused they are asked to provide service for. Other participants felt that one of the largest challenges is their heavy workload and the fast paced environment in which they work. One participant stated,

> *"Time is sometimes the limitation. We cannot deal with every case that everyone wants. An accused might want to get a matter resolved, or a defense counsel wants to get something resolved and we have to turn them away."*

Another challenge that participants report is a lack of resources in the community to which to refer accused. Since January 2005, an initiative that the Ministry of Health and Long-Term Care has been investigating is developing a network of resources to support individuals living with mental illness who also have a criminal history of non-violent

offences. The McGuinty government agreed to invest $27.5 annually into community mental health agencies to provide services to individuals living with mental illness. An expansion of services was promised in five areas: crisis response and outreach, short-term residential crisis support beds, court support services, intensive case management services and supportive housing services (Ministry of Health and Long-Term Care, January 15, 2005). Participants in this study found that this initiative has been helpful but they did not feel that it was enough to support the accused in the Mental Health Court.

Additionally, all participants found that poverty is a challenge that many accused individuals face. Poverty is a barrier to one's ability to comply with the requirements placed upon him or her, including attending court dates, following bail conditions and following through on diversion. Some participants believed that it is inadequacy in income support from social services, such as income support from the Ontario disability support program, which is responsible for the poverty that the accused suffer from. They also felt that there is a false perception of the court's ability to assist individuals living with mental illness. That is, if an individual is considered fit but still suffers from an illness they would be remanded to the originating court, from which they came, and no additional services provided by the court. Another challenge associated with this is the divide between the mental health and the rest of the criminal justice system. The court only helps individuals through the criminal justice system, but does not assist these individuals with their overall mental health issues. For instance, once the accused is considered 'fit', the role of the psychiatrist is almost nil even though the accused may be suffering from a mental illness. Therefore, the psychiatrist cannot help the client any further since his or her role is only to complete a fitness assessment. Participants report that this can be very frustrating since they want to help these accused but it is not their role in accordance with the criminal code.

Rewards

Participants agreed that one of the major rewards of working in the court is seeing individuals suffering from a mental illness who, after receiving treatment, have the opportunity to put their life back together with support in the community. In addition, it

was agreed that it was rewarding to see an individual expedited through the system efficiently and seeing individuals successfully completing diversion programs. The Mental Health Court was also considered to be a rewarding place for seeing accused suffering from a mental illness as individuals and not ostracizing them due to their symptoms. Participants attribute this to the level of education and understanding of individuals who work with or in the court. One participant stated:

> *"the good thing about working in this court is seeing the number of professionals out there...that are very understanding of mental health issues...it is rewarding to work with different people to help"*

and support the accused. Another participant stated,

> *"I think that the mental court employees treat people with a lot of dignity in the court as much as we can...I believe is that the people who work in the court are a pretty compassionate group of people"*

One participant indicated that it was rewarding to see clients improve and meaningful when they are able to build a relationship with clients and understand them based on culturally congruent services. For instance, after speaking to a client in the client's own language and having a good understanding of cultural factors, a client was comfortable enough to disclose that he or she was feeling like hurting him- or herself as well as the family. He states *"since the client had disclosed this information I was able to address and get client treatment and prevent safety risk to the client and to others."* Therefore, it is rewarding to build therapeutic relationships that help the client's recovery. Another participant stated, *"the most rewarding thing is seeing someone come in quite crazy and out of control and seeing them walk out all together... this is a major objective".* Additionally, another participant felt it was rewarding to see a client be successful, but attributed this to the flexibility of the court and their understanding of mental illness. Other participants felt that it was rewarding to work with other players in court especially when achieving successful results. It was also considered rewarding when participants

had the opportunity to not only connect an individual to community resources but sometimes also reconnecting the individual with the family of origin for even more support.

When discussing the functioning of the court, it is important to note that the Ministry of Health and Long-Term Care announced the second phase of the January 2005 initiative to support individuals living with mental illness to stay out of the criminal justice system in May 2006. The McGuinty Government announced an expansion in community mental health services investing $68.5 million in new funding. This is reportedly being done in an effort to improve mental health and addictions services with $22.5 million earmarked for community-based services to assist individuals living with mental illness in avoiding involvement in the criminal justice system (Ministry of Health and Long-Term Care, May 20, 2006). Additionally, the McGuinty government has proposed to improve hospital care by funding 75 new forensic beds to support those individuals who are living with mental illness and involved in the criminal court system in obtaining the services they need (Ministry of Health and Long-Term Care, May 20, 2006). These initiatives could benefit the functioning of the Mental Health Court greatly. Access to more forensic beds could result in decreased waiting times for accused who are directed to hospital care on either treatment or assessment orders. These initiatives can also be potentially helpful to the community workers who work with the accused in accessing support from the mental health system.

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[i] This is an initiative led by Health Canada and developed in collaboration with other relevant government departments and relevant non-government departments in order to reduce the supply and demand of illicit drugs. Its goal is to ensure that members of the Canadian society are able live free of the harmful effect of substance abuse (Health Canada, 1998).

[ii] The funding program is a part of the Canadian Drug Strategy. The program is managed by the Department of Justice and Health Canada. The program is available to variety of different organizations and governments – national, provincial, territorial, municipal and Aboriginal etc. The objective of the funding program is to strengthen alternatives to incarceration, to build public education surrounding drug treatment courts and evaluate drug treatment court in order to determine best practices and refine approaches (Department of Justice, October 20, 2005).

[iii] In this model of justice the process and rules of a traditional court model are regarded as secondary and what is considered primary is the whole defendant and provision of some type of treatment. Therapeutic justice looks towards the present and future behavior of the accused as opposed to the traditional criminal model which focuses on past behaviors of the accused and their consequences (Conference of State Court Administrators, 1999).

[iv] Form 48 under section 672.13 of the Canadian criminal code is an assessment order placed on an individual when the judge would like to have an assessment of the mental condition of the accused to determine "whether the accused is unfit to stand trial, whether the accused suffered from a mental disorder so as to exempt the accused from criminal responsibility" etc.

[v] According to s.672.11 of the criminal code, the court has the broad discretion to require an assessment of the mental condition of the accused in the course of a preliminary hearing, indictable appeal, indictable trial, summary conviction trial and summary conviction appeal. The assessment order may be used to determine "(1) fitness to stand trial; (2) exemption from criminal responsibility as a result of mental disorder; (3) mental condition with respect to infanticide; (4) the appropriate disposition where the accused is unfit to stand trial or not criminal responsible on account of mental disorder and (5) whether or an order pursuant to s.747.1 (1) detaining and accuses in a treatment facility subsequent to conviction if necessary"

[vi] In s.672.58, a treatment order is when the accused is unfit to stand trial. The court may, on application by the prosecution, direct that the accused to remain under treatment for a period no longer than 60 days; within such an order the court may order additional conditions deemed appropriate.

[vii] A surety is a person, typically a family member or a friend, who is willing to pledge a certain amount of money and promise the court that he or she is willing to ensure that the accused attends court as required and follow the conditions stipulated by the bail.

[viii] According to s.579 of the criminal code, a Stay of Proceedings occurs after the accused has been charged and prior to a judgment being rendered in the case; the crown may direct the proper officers of the court to stay the proceeding. Proceedings can be 'stayed' or placed on hold for either an indictable or summary charge. Proceedings which are 'stayed' in accordance to this section of the criminal code may be recommenced without laying new information or "preferring a new indictment".

The Stigma of Mental Illness:
An Inquiry into the Toronto Mental Health Court and whether it reduces the stigma of mental illness for those accused of crimes

Chapter 5: Stigma and the Toronto Mental Health Court

The purpose of this chapter is to review the second section of research findings on the impact of stigma related to mental illness in the Toronto Mental Health Court. I will begin by examining the presence of stigma and its impact on other specialized drug and mental health courts across the U.S.A and Canada. Following this overview, I report on my research findings on the Toronto Mental Health Court. These findings start with a general overview of participants' responses and observational research findings of the Toronto Mental Health Court and stigma. I will continue by reporting findings on the presence of stigma related to mental illness in court and the participants' responses to whether the court addresses stigma. Lastly, the final two sections of the chapter examine the impact of stigma on the court through its structure and functioning.

Bruce Link et al.'s theoretical perspective on stigma related to mental illness is utilized throughout this chapter to: determine the presence of stigma in the court; review the impact of stigma related to mental illness in the court; and assess whether the court is effective in reducing the stigmatization of those accused of crime. It is through Link et al.'s theoretical perspective that this study concludes that stigma is present in the structure and functioning of the Toronto Mental Health Court. However, it is important to note that my research demonstrates that the Toronto Mental Health Court aims to and does decriminalize the accused by providing support in a non-adversarial environment – with knowledgeable staff, the support of mental health experts and the possibility of diversion opportunities for the accused. As such, this decriminalization reduces the amount of stigma that an accused encounters and is beneficial in reducing the amount of stigma the accused experiences in the criminal justice system. Although the stigma of being labeled as living with a mental illness is present in the structure and functioning of the court, the benefit of potential decriminalization outweighs the consequences of this label.

Stigma and Drug Courts:

As discussed in Chapter Four, the success of drug courts in the U.S.A and Canada is the catalyst in developing of mental health courts. Based on evaluations of drug courts, the accused appear to experience stigma in two significant ways. Within the first form of stigma, the accused encounters being in-conflict with the law and criminalized. The second form of stigma is being a labeled a 'drug user'. There are two perspectives in understanding the impact of stigma on the accused which appear before drug courts. From the perspective of Bruce Link et al. (2001), drug courts contribute to the stigma. The accused is confronted and only eligible for this program after he or she is labeled as a drug-user. As such, this label outlines how the accused in the drug courts have a different and undesirable label than other accused in the mainstream criminal justice system. Consequently, the label of being a drug user will likely have a negative impact on accused. Accused who are labeled as drug-users are vulnerable to further experience a loss of status and discrimination based on the label. A more positive perspective to consider when evaluating drug courts is to look at the key components of these courts.

The central goal of drug courts is to reduce recidivism rates and to provide court-monitored treatment for the accused (National Association of Drug Court Professionals, 2000 and Toronto Drug Treatment Court, May 31, 2006). If the aim of the drug courts is to decriminalize the accused, this is achieved by reducing the criminality and hence, the dual stigma experienced by accused who appear before the court. Like the Toronto Mental Health Court, the benefit of decriminalizing the accused and reducing the amount of stigma prevails over the stigma of being labeled as a drug-user.

Stigma and Mental Health Courts:

Similar to the accused in the drug court system, the accused that appear before the mental health courts also experience the stigma of being in conflict with the law and the stigma of living with mental illness. As stated above, stigma and specialized courts can be viewed in two different ways. First, utilizing Bruce Link et al.'s perspective on stigma, mental health courts in the U.S.A and Canada appear, by virtue of labeling the accused, to be stigmatizing. According to Link et al., these labels contribute to stigmatization and

have a negative impact on the life of the accused. For instance, Link et al. (1982) in their article on Modified Labeling Theory find that even if labels do not create mental illness these labels have a negative impact on individuals labeled as living with a mental illness. From Link et al.'s perspective, the stigma of being labeled as living with a mental illness can have a negative impact on an individual's social situation (employment, housing, social relationships). As such, the label placed on the accused persons that appear before mental health courts can have a negative impact on them and is stigmatizing.

Second, one of the central aims of mental health courts is to reduce recidivism and provide court monitored treatment (Denckla and Berman, 2001). They attempt to decriminalize the accused living with mental illness by trying to divert them out of the criminal justice system and helping them to access treatment. By de-criminalizing the accused which appear before these courts, the courts reduce the amount of stigma experienced by the accused. The benefits of these mental health courts is in reducing the amount of stigma experienced by the accused to access the support of mental health services and decriminalizing them. Again, the benefit of receiving support through the criminal justice system outweighs the consequence of being labeled.

Stigma and the Toronto Mental Health Court:

Since the concept of stigma has been operationalized using Bruce Link et al.'s theoretical perspective, I will reflect on this perspective to analyze the data collected in my observations and interviews in determining if stigma is present in the structure and/or the functioning of the Toronto Mental Health Court. Similar to Link et al.'s conceptualization of the term 'stigma', all of the participants in the study considered stigma a negative label developed through perceiving an individual as different because of an undesirable characteristic such as symptoms, diagnosis or history of mental illness. Additionally, like Link, participants felt that there are consequences associated with an individual being stigmatized based on their mental illness, which includes being shunned by society or isolated from others.

One participant reported that she found it interesting that groups, stigmatized and marginalized, are likely to further marginalize other groups. For instance, the participant described a situation where one of her clients lived in a low income apartment setting and that her client was labeled as *'crazy and mental'* by other tenants in the apartment complex who wanted this client evicted from the building based upon this label. It is interesting to see that one marginalized group (individuals living in low income housing) can further marginalize others (individuals living with mental illness) based on what they perceive as different.

A majority of participants agreed that stigma was a factor that their clients or the accused encountered. All of the participants agreed that there were two types of stigma which these individuals encountered. The first type of stigma results from living with a mental illness and the second results from being in conflict with the law. Participants disagree on which of these stigmas are more powerful or significant. A majority of the study's participants felt that the clients' criminal involvement was much more stigmatizing than their mental health issues. They believe that this is evident by discussing the common occurrence of the accused being denied mental health services on the basis of their forensic history. For instance, one participant said that a number of the clients being assisted were denied services through the mental health system because they were perceived as dangerous. However, when the participant was working in an emergency healthcare setting he stated,

> *"I also worked at a hospital doing crisis work and what I found very interesting was a lot of people who come into crisis, brought by the police to emergency; I had previous contact with at the court... but the people working at the hospital did not know that... so they are actually working with the population that they are afraid of and... they are not aware of the criminal charges... as soon as they become aware they have criminal charges that is the moment they do not want to deal with them... I guess there is a certain irony to that."*

On the other hand, two participants felt that it was the label of being mentally ill which brought these individuals into the criminal justice system in the first place. One example given is that an individual is arrested for stealing a can of 87 cent pop from a local Zellers store. The court employee states,

> *"I think that if the person was not mentally ill or disheveled or smelly, I have little doubt that they would have been given a notice to appear and probably would have been released on the spot".*

Stigmatization of the accused was also considered to be something that was compounded by a variety of factors. Stigma did not only relate to the individual's mental illness, but was further exacerbated by their present or pending criminal record, homelessness and sometimes a dishevelled appearance. The greater number of factors that marginalize individuals, the greater the stigma they experience and subsequently the more difficulty they have accessing services.

A number of the participants also felt that the stigma of mental illness was a pervasive factor which their clients dealt with regularly, which was de-humanizing for them. One participant reported that a number of clients are afraid to disclose that they live with a mental illness for fear that it will limit their opportunity for educational pursuits, vocational pursuits, and even interpersonal relationships. Another participant in the community said that the stigmatization of her clients was even visible within the organization that she worked, as some of her colleagues approached her stating *"I am so happy we have someone working with the crazy people"* and referred to the Mental Health Court as the *"crazy court"*.

The Presence of Stigma in the Mental Health Court:

Participants disagreed on the extent to which the court's structure addressed the issue of stigma and negative labeling. Some participants felt that that the structure did reduce stigma based on the implementation of the diversion program. The diversion program attempts to get people out the criminal justice system, de-stigmatizing the

accused and saving them from being labeled a criminal. Participants expressed that the court is more sensitive and compassionate towards individuals living with mental illness, treating these individuals with more dignity and respect than other courts. One participant described how employees of the court have a higher tolerance for people who may be yelling out inappropriate phases during the proceeding. The court is more patient with accused persons, allowing them to speak their mind and listening more attentively, where mainstream criminal courts are traditionally less tolerant.

Other participants felt that the structure of the court is not formally designed to address the issues of stigma or negative labeling. They found that the structure does not address stigma and negative labeling but rather it was the players involved in the court functioning that addressed these issues. It was noted that court officers requested to work in the mental health court by virtue of wanting to work with this population. The crown attorney and presiding judges are considered expert in understanding mental health issues, which in itself works to address the issue of stigmatization and negative labeling. Another participant states, *"I think that the people involved do their best to reduce stigma"*. Other participants felt that the court structure did address the issue of stigma by virtue of recognizing that the clients they are dealing with have some form of mental health issues. However, these participants agreed that addressing stigma was not part of the court's formal structure.

Conversely, one participant argues,

> *"... by virtue of having a court and calling it a Mental Health Court that it could potentially create stigma is implicit in that mental illness is criminalized... and that mental illness causes people to come into conflict with the law in the first place"*.

A study completed by Link et al. (1987) found that individuals labeled as living with a mental illness are more likely to be stereotyped as dangerous then individuals who do not share this label. This finding is supported by the Link et al. argument that individuals

living with mental illness are at risk of being criminalized prior to encountering the criminal justice system and having a court specially designated for this population enhances the stigma of dangerousness associated with mental illness. As such, stigma is present in the structure of the Toronto Mental Health Court which has a negative impact on the accused.

Participants were also asked directly whether they had ever witnessed stigmatization of an accused in the court. Internal and external participants provide mixed responses as to whether they had witnessed stigma in the Mental Health Court. Some participants felt that they had never witnessed stigma in court. They believe that the court leaves a positive impression and that people try to be transferred to it because it is not belittling. In fact, the court is considered more lenient. Two participants reported that they have never witnessed stigma in the court and another states *"stigma is something that is ongoing and exists... stigmatization and stereotypes are socially common; and we all engage in it."* However, another participant felt that the court does its best to minimize stigma by having more severely mentally ill individuals appear at the end of the day, when there are less spectators in the court.

On the other hand, some participants admitted to witnessing stigma in various ways by different players. For instance, one participant describes how some accused individuals are stigmatized in the early stages of the process by the derogatory police reports sent to the court or by the police officers' lack of knowledge about mental illness. For instance, some police officers have described individuals as appearing drunk. An example provided by the participant is that,

> *"... there is an accused that I can think of, that by virtue of his disorder, who always appears drunk... he gets very violent when he is cornered...so he constantly gets stigmatized and re-arrested by the police...for behaviour he can not control."*

Other participants implicated in stigmatizing the accused include court officers and some defense counsels. Court officers have been reported to make fun of accused and some have even been noticed making faces. In another case, defense counsel have been considered to be quite stigmatizing in their discussions with other individuals working in the court by referring to their clients' as *'crazy nuts'* and/or *'off on some other planet'*. Other defense counsels have argued that their client is *'so whacked that they need to be put away'*. Three other participants reported witnessing the stigmatization of accused in the court. All three agree that court officers had been seen stigmatizing the accused in the court by being unsympathetic and making fun of the accused.

As mentioned in previous participant responses, stigma exists in the Mental Health Court since it creates a perception that individuals living with mental illness are more likely to come into conflict with the law. From participants' comments, it appears that those more likely to engage in stigmatizing the accused are the court officers and some attorneys. Unfortunately, court officers were not interviewed in the study and unable to speak to the issue. Link et al. (2001) relates stigmatization of individuals living with mental illness to power. This perspective on stigma and power is helpful in understanding the reported stigmatizing practices of some court officers and some attorneys. Link et al. describes the stigmatization process as completely reliant upon access to social, economic and political power, which allows individuals to: identify differences, construct stereotypes, label persons as different and subsequently discriminate against them. In the case of the Toronto Mental Health Court, power resides with the court employees (court officers, attorneys etc.) and not in the hands of the clients. It is the court employees who possess social, economic and political power which enables them to stereotype label and discriminate against the accused. Accordingly, these court actors are the source of stigma in the functioning of the court since they label and stigmatize accused. Subsequently, the accused are vulnerable to such stigmatization because they do not posses the same amount of social, economic and political power.

The Toronto Mental Health Court's Impact on Stigma:

Some participants believe that the Mental Health Court has a positive impact on individuals living with mental illness for a number of reasons. First, employees who work in the court have a good understanding of mental health issues and are not afraid to approach the accused. One participant states that the court *"tries to provide an example for others to treat people with dignity and respect exemplifies this... I think that really is the core of it"*. Second, two people argue that the court has a positive impact because of the lenient conditions of the court. For instance, some of the accused may get bail in the Mental Health Court where they would not otherwise have had that opportunity in the mainstream criminal court system. Stigmatization of accused is viewed to occur outside of the mental health court, because the Toronto Mental Health Court has been referred to by others from different courts as a *"place where nuts gather"*.

On the other hand, a smaller number of participants felt that they were unable to assess the impact the court has, since no data has been collected to determine recidivism rates of offenders that come before the Mental Health Court. One participant stated,

> *"... the objective is not to have a revolving door by trying to make plans before an individual is discharge... we do not have any data... but our sense is that we are doing a good job."*

Instead of responding to whether the court had a positive or negative effect on accused, 6 of the 12 participants focused on different aspect of the Toronto Mental Health Court and stigma. Some of these participants felt that the court is positive because it is sympathetic to the need of an individual with mental illness as it provides better treatment than other courts. For instance, one participant comments that in the mainstream criminal court an individual is released from custody wearing an orange detention centre jump suit rather than assisted to access regular clothing upon his or her release. Another participant believes that,

"... by virtue of having a Mental Health Court there is the recognition of the special needs of this population and that these needs are responded to by the specially designated staff of the court".

Conversely, another participant reported that some accused persons are sent through the Mental Health Court stream even when they do not want to be there. These individuals attempt to stay away from the Mental Health Court because they do not want to be labeled as living with a mental illness. In such circumstances, the court arguably does contribute to stigma.

Examining Stigma and the Mental Health Court:

As discussed in the previous chapter, Bruce Link and his colleagues have completed a number of studies to identify the presence of stigma. Link et al. explain the process of stigmatization and the steps used to determine the degree to which stigma exists. This work demonstrates how some groups experience greater stigma than others. For instance, those groups that suffer from two stigmatizing factors will be more stigmatized than a group that suffers from only one stigmatizing factor. As discussed earlier in this chapter, individuals who live with a mental illness and have a forensic history are likely to experience a larger amount of stigma than those only living with a mental illness. An examination of the Toronto Mental Health Court and the impact of stigma are demonstrated though utilizing the Link et al. theoretical perspective on stigma related to mental illness. I use the Link et al. theoretical perspective to determine whether stigma exists in the structure and function of the court. As a result of the creation of the Toronto Mental Health Court and through utilizing the Link et al. theoretical framework, I conclude that, the court reduces the stigma of criminality. Therefore, by reducing the stigma of criminalization, the Toronto Mental Health Court has a positive impact in reducing the amount of stigma the accused faces.

Stigma and the Structure:

In order to understand the structure of the Toronto Mental Health Court, participants were asked a number of questions. These questions aimed at achieving a

clearer understanding of the organization of the court. It was through the responses and observational data collected that Link et al.'s perspective is used to examine the existence of stigma. Using Link et al's framework, my findings conclude that there is evidence of stigmatization of individuals living with mental illness in the structure of the Toronto Mental Health Court. Using observational data and participants' responses, a modified flow chart explains the structure of Toronto Mental Health Court (Figure 1.5) and identifies areas where the accused is stigmatized on account of their mental illness.

Figure 1.5: Stigma and the Structure of the Toronto Mental Health Court

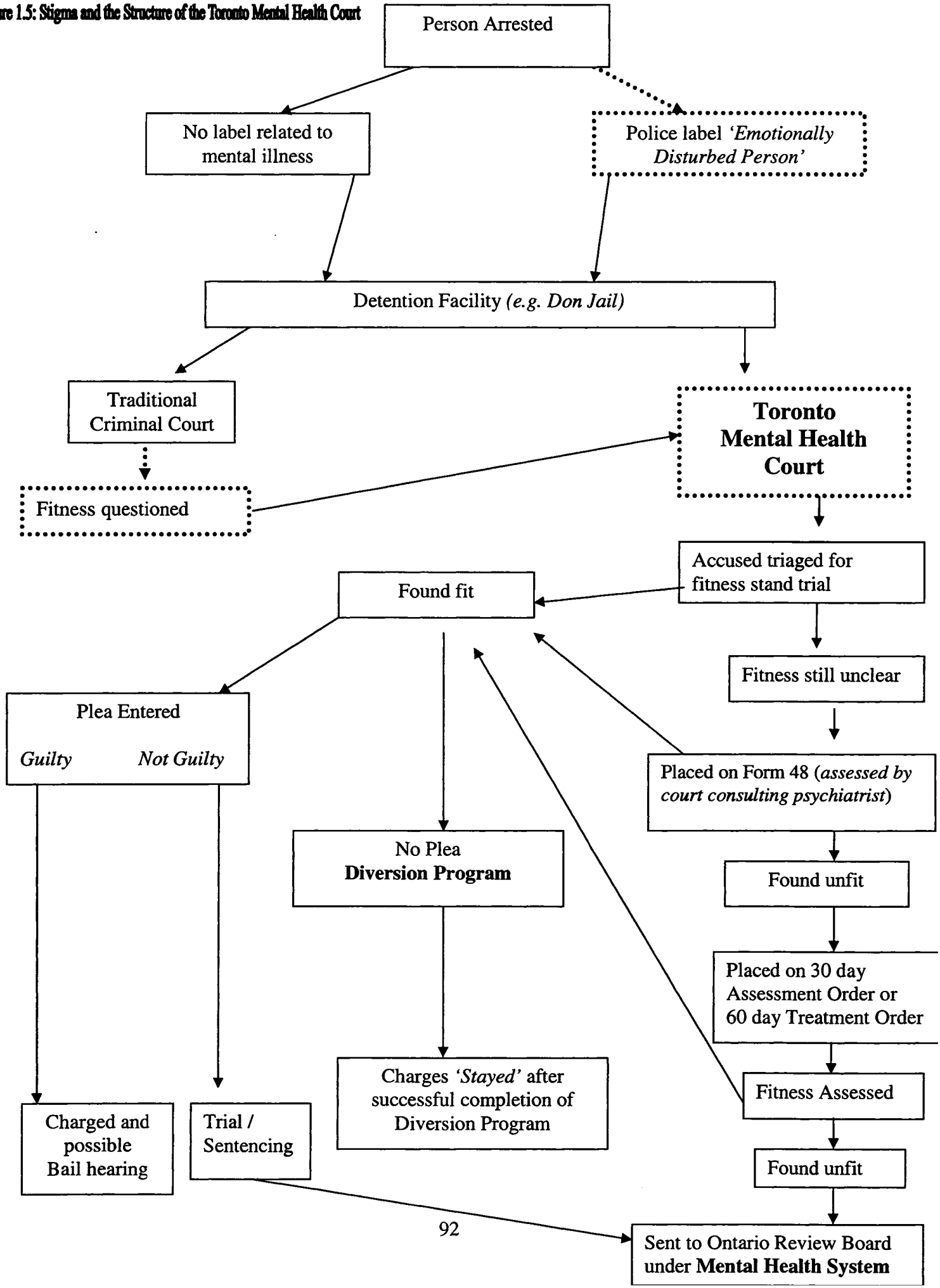

Figure 1.5: Stigma and the Structure of the Toronto Mental Health Court

In Figure 1.5 stigma occurring in the court's structure is indicated through the use of dotted lines and boxes. The figure shows how stigmatization of the accused living with mental illness occurs early when first entering the criminal justice system. Upon arrest, if an accused is labeled an *EDP* by police, the individual is stigmatized as possibly having a mental health issue. According to participants, another area where the accused is vulnerable to becoming stigmatized is when fitness is questioned in the mainstream criminal court. This vulnerability occurs because mainstream criminal courts are not structured to have mental health expertise supporting them.

Stigma is also present in the Toronto Mental Health Court by the way in which it processes offenders. As described previously, one of the primary ways that the court operates is to determine the fitness of the accused. If accused persons are found to be fit to stand trial, they are typically transferred back to the traditional criminal court stream. Even if an individual suffers from a mental illness, that person can still be found fit at the time of assessment. As such, this accused is not connected to further support from the mental health system and can be placed back in the mainstream criminal justice system with no treatment or support.

As noted earlier, power is an essential element to the process of stigmatization which is emphasized in Link et al's theoretical framework. Using Link et al.'s theoretical perspective to analyze the Toronto Mental Health Court, the court is a provincial body which has a great deal of social, economic and political power that it utilizes to achieve access to the mental health system. This power is demonstrated every time they find an accused 'fit' or 'unfit' to stand trial. By determining this status, the court has the power to determine whether an accused is eligible to receive further assistance from the court and be connected to the mental health system, or be transferred to the mainstream criminal justice stream. If an accused is considered fit as well as living with a mental illness, the court does not assist them in accessing the mental health system and accessing the assistance of mental health professionals. One participant explains,

"... that when the mentally ill offender is actually fit for trial, the role of the psychiatrist is almost nil. All that the psychiatrist does, is establish whether the person is fit, and that is the end of their involvement... this is a little bit frustrating".

The person deemed fit likely has much less social, economic and political power than the court actors. Therefore accused individuals and their families may have greater difficulties accessing the support of the mental health system and are left more vulnerable to further criminalization. Further to this, power resides in the court actors such as the presiding judge and consulting psychiatrist since they are the ones who assess and determine the fitness of the accused. It is only when the accused is considered unfit that the accused can access the support of the mental health system. Accused who are considered fit are not provided the same opportunity to access the treatment support of the mental health system. As such, accused persons who appear before the court have less power since they are unable to control whether they are able to access support of mental health services and whether they are appropriate candidates for the support of the Mental Health Court.

By virtue of its name, the Toronto Mental Health Court stigmatizes the accused. The labeling process that accused individuals who appear before the mental health court experience can be explained by Link et al.'s four criteria describing the existence of stigma. That is, by labeling accused persons as possibly suffering from a mental illness they are considered to be different from others in the mainstream criminal justice system. Since the perception of mental illness is often considered to be negative, this difference is often deemed to be an undesirable characteristic. For instance, a participant explained that some accused individuals did not want to be sent to the Mental Health Court because they feared the stigmatization they will experience in the community due to the way the media has traditionally represented individuals living with mental illness. She states *"they would rather be considered an addict than a person that has mental health problems"*. It is evident that by the court's existence, there is a differentiation made

between accused sent to this court and those in the mainstream criminal court stream. Another participant states,

> *"the mere existence of the Toronto Mental Health Court is stigmatizing. There are a number of people who would prefer not to have mental health diversion, because they do not want that label. However, for a lot of people going through the system they do not have a choice"*

Lastly, accused individuals appearing before the court experience discrimination due to the structure of the court through the lack of support for them in the community when released. Lack of services in the community for accused that appear before the court further supports the existence of stigma in the Mental Health Court's structure. By being identified as being involved with the court, the accused is associated and stigmatized as having a forensic background. Although accused individuals may require support for dealing with their mental illness, a number of mental health providers are hesitant to accept them due their association with the court. One participant states,

> *"I believe that stigma exists outside of the court in the community. Stigma is present in the community when we are trying to reconnect them back to the system and they are not accepted by community resources because they are associated with the stigma of the court. Stigma is institutional and we have to address it with education. Not just within in the court but in the general public"*

Another participant states,

> *"I think that anybody involved in the criminal justice system, automatically has a stigma attached to them by virtue of being in contact with the law. It is without question that individuals who appear before the mental health court experience a level of stigma that goes well beyond this due to the stigma of being labeled with a mental illness. The stigma of mental illness gives people the impression that these*

individuals may be deficient and that they are dangerous. This is a huge barrier in advocating for these individuals"

Therefore, using Link et al.'s four characteristics to conceptualizing stigma, it is evident that stigma is present in the structure of the court.

Link et al.'s Modified Labeling Theory is used to demonstrate the second example of stigma in the structure of the Toronto Mental Health Court. A number of participants in the study have reported that accused who appear before the court have the unique experience of having to deal with the dual stigma of living with a mental illness and being involved in the criminal justice system. The effect of the dual stigma is evident in the mental health system where individuals involved in the Mental Health Court often have more difficulty accessing mental health resources in the community. For instance, a number of participants reported that their clients of the Mental Health Court were turned away from support because of their forensic history. This fits Link et al.'s Modified Labeling Theory where the label of 'forensic mental health patient' has a negative impact on these individuals' social situation because they are often denied access to mental health services due to their forensic history and do not receive support to re-integrate into the community. Community mental health services traditionally support individuals living with mental illness to overcome stigma by assisting with housing, employment and providing health teaching for these individuals' families. One participant states,

"In the mental health system no one wants a tough forensics patient. They may be clinically identical to the other individual that they are treating for schizophrenia...the stigma is enormous. You have agencies that formally refuse to accept forensic patients."

As such being involved in the criminal justice system hinders the ability of an accused to be serviced by the mental health system and places that person's mental stability in jeopardy. According to the finding of this study, being labeled with a forensic history has a greater negative impact than the label of mental illness. The Toronto Mental Health

Court like other specialized courts aims to decrease the dual stigma by decriminalizing the accused which appear before the court. This is demonstrated by a majority of participants who report that the purpose of the Toronto Mental Health Court is to provide specialized support for the accused by providing assistance and liaison to services in the mental health system. The court decriminalizes those who appear before it by providing a more supportive environment to the accused. If the court is successful in achieving its purpose of decriminalizing accused, it can be effective in reducing the amount of stigma experienced by the accused. Therefore, the court benefits of decriminalization and receiving support overcome the label of mental illness which the accused receive.

Stigma and the Functioning:

In the functioning sections of the interviews participants were asked directly and indirectly their opinions of whether stigma exists in the daily functioning of the court. Using Link et al's theoretical perspective to analyze the presence of stigma, it is evident that stigma is present in the functioning of the Toronto Mental Health Court by the actors who run the court. Three instance of stigma have been found to support the argument.

First, through interviews with court employees and community workers, court officers have been considered individuals who have been witnessed to stigmatize the accused. Participants have reported that they have found court officers to make fun of and make faces at the accused. Court officers were not interviewed in this study and were unable to respond to their impression of stigma of mental illness in relation to the functioning of the court. Secondly, members of defense counsel were also considered by one participant to be involved in stigmatizing the accused by the terminology they used when consulting the other participants in the court.

Another participant states, *"mental illness makes people feel very uncomfortable"*. The participant used the example of one specific accused who appears before the Toronto Mental Health Court more regularly *"who does not attend to their hygiene, does some very bizarre self talk and appears in court in costumes"*. The participant continues on to discuss how this accused *"makes people in the court feel uncomfortable and that they*

chuckle when this accused is in the courtroom...which only serves to isolate the accused further".

In accordance with Link et al.'s theoretical perspective, an individual is able to stigmatize based on having social, economic and political power. Court officers and defense counsel have more social, economic and political power than the accused living with mental illness; this power allows them to stigmatize the accused. This stigmatization has a negative impact on the perception of the accused by others in the court. For instance, since the defense counsel is stigmatizing toward individuals living with mental illness and his or her role is to advocate on behalf of an accused, the manner in which he or she defends the accused can be very negative and stigmatizing. Most importantly, defense counsel can have a negative impact on the judge's ruling in the case, particularly on whether and when the accused can return to the community.

It was during the course of some interviews with participants who worked in the court that stigma was evident. Some participants described individuals living with mental illness as being *'crazy'*. Although, I do not believe that this terminology was intentionally used to be stigmatizing, the presence of stigma is evident in the terminology used by one participant when asked the reasons an accused appears before the court. The participant describes an individual who was brought in by the police after he is found on the street *"screaming to the Gods... pretty soon he is causing a nuisance, hits someone, pushes someone off a subway platform and attracts the attention of the police".*

It was apparent when interviewing some participants that there is some evidence of underlying beliefs that may have a negative impact on the accused who appear before the court.

Stigma and the Structural Effect of Race/Class/Gender

The structural impact of race, class and gender are touched upon briefly in terms of demographics in the previous chapter. Through observation research, information was collected on the race, class and gender of the accused. Information regarding the race and

class of the accused was determined at the discretion of the researcher. It is difficult to have a concrete population demographic of the accused individuals who appear before the Toronto Mental Health Court. Given the nature and direction of my research, I am unable to comment on the impact of these structural factors. As such, more observational research concentrating on race, class and gender of the accused who appear before the Toronto Mental Health Court is required to determine whether these factors impact stigmatization. The concluding chapter discusses this issue further.

Chapter 6: Conclusion

The relationship between the Canadian mental health and criminal justice systems has continually interested me. This interest led me to want to achieve a greater understanding of the structure and functioning of the first specialized Mental Health Court in Canada. By having a clearer understanding of the role of the Toronto Mental Health Court, I have had the opportunity to determine its impact on individuals living with mental illness, specifically with regards to stigmatization. At first glace, the concept of a specialized court specifically designated to serve individuals living with mental illness appears to be a positive movement towards reducing the stigma of mental illness for those accused of crime. A specialized court with designated personnel familiar with mental illness appears to operate by helping individuals living with mental illness to receive appropriate supports and by liaising them back to the mental health system. The primary question of this study was whether the Toronto Mental Health Court does accomplish this and whether it reduces the stigma of mental illness for those accused of crime.

Operationalizing the theoretical framework outlined by Bruce Link et al. on stigma and mental illness, I have determined that stigma is present in both the court's structure and its functioning. Although stigma is present in the overall structure and functioning of the Toronto Mental Health Court, it is important to take into consideration the purpose of the court to determine its impact on stigma. The non-adversarial and supportive approach that the court takes in servicing accused living with mental illness reduces the stigma of the accused being criminalized. Therefore, by reducing the stigma of criminalization, the Toronto Mental Health Court has a positive impact in reducing the amount of stigma that the accused face.

Structure and Stigma:

One of the key findings about the structure of the court is that by virtue of having the court and labeling it a Mental Health Court, there is the presence of stigma in the court itself and on those who appear before the court. That is, all individuals who appear before the court are labeled with the possibility of living with a mental illness which further stigmatizes them. As such, some participants have noted that some accused individuals who appear before the Toronto Mental Health Court prefer to be transferred to the mainstream criminal court stream in order not to have this label attached to them. A key component to the structure of the Mental Health Court is the concept of labeling the accused. The process of labeling strengthens the presence of stigma in the organization of the Toronto Mental Health Court structure. This same finding of further stigmatization is supported by another study written on the implications of specialized mental health courts in the U.S.A. (Tyuse and Linhorst, August 2005). This study concludes that Mental Health courts actually increase stigmatization and criminalization. Stigma is considered to become stronger once the criminal court system is related to the mental health system. There is also a fear that more individuals living with mental illness will be charged with offences in order to get support from services in the courts, which in turn further criminalizes them (Tyuse and Linhorst, August 2005).

From the initial encounter the accused has with police, the accused is either labeled as an *"emotionally disturbed person"* or has no label at all. From this initial labeling process, it is determined whether an accused will go through the mainstream criminal court system or be labeled further by being transferred to the Mental Health Court. If labeling does not occur at this initial stage, it occurs during the first court appearance when the fitness of the accused is placed in question and they are labeled with the possibility of having a mental illness.

Stigma is also present in the Toronto Mental Health Court structural purpose to complete and hasten fitness assessments in the criminal justice system. Upon examination of the Toronto Mental Health Court, one of the primary responsibilities of the court is to

determine the fitness of the accused to stand trial. That is, if an accused is found to be living with a mental illness and is stable and competent to stand trial, the role of the court in supporting the accused is slim to none. Therefore, an accused who is found fit is typically transferred back to the mainstream criminal courts and provided little to no support in accessing the mental health system. As such, these individuals continue to be vulnerable and 'fall through the cracks' as they may be unable to access the support of the mental health system and, in some cases, left with the burden of a criminal record. Under these circumstances, the Toronto Mental Health Court does not provide any support in reducing stigma.

Functioning and Stigma:

As discussed in the previous chapter, there is a clear presence of stigma within the daily operations of the Toronto Mental Health Court, where participants interviewed have reported incidents of stigmatization by court officers and defense lawyers. Although a number of court personnel interviewed in the study have extensive experience working with and supporting individuals living with mental illness, there is still evidence of stigma being present. Most surprisingly, a participant interviewed in the study used stigmatizing and labeling terminology when describing the reason for which an individual may be sent to the court. An effort to be less stigmatizing is evident as a non-adversarial approach is implemented and employees of the court work in a collaborative manner in order to support the accused through the justice system. For instance, since a number of employees of the court are knowledgeable about mental illness they demonstrated more sensitivity, patience and compassion towards the accused. It appeared that those individuals who work in the court that have less experience and knowledge surrounding mental illness, tend to be more stigmatizing. Since this study concentrates only on the Toronto Mental Health Court it is difficult to conclude whether the amount of stigma present is reduced in comparison to the mainstream criminal justice system, since stigma was not examined in the mainstream court system.

The Impact of Race, Class and Gender on Stigma

Through observation research, information was collected on the race, class and

gender of the accused. Since this categorization was established at my own discretion as the principal researcher, it is difficult to have a concrete population demographic of the accused who appear before the Toronto Mental Health Court. More formal research concentrating on race, class and gender of the accused is required to determine if and how these factors impact on stigmatization. I have found that there is a larger number of Caucasians accused in comparison to minority groups who appear before the court. Further research would be of value in determining whether particular groups experience a greater amount of stigma due to their racial and or cultural background. Additionally, it would be of value to determine whether the gender and class of the accused play a role in further stigmatizing them. For instance, would an Asian woman from a lower socio-economic background experience greater stigma than a white male from a middle class background? Would this woman experience stigma in addition to the stigma of living with a mental illness and would this stigma impact on her experience in the Toronto Mental Health Court. Are accused who appear before the court more vulnerable if they come from a minority or do they receive the same treatment as other accused from non-minority groups?

Observational research of the court found that a majority of employees who worked in the Mental Health Court were Caucasian. As such, the staff who are employed in the Mental Health Court do not appear to be representative of the multi-cultural population of the Greater Toronto Area. One participant felt that there was a lack of culturally sensitive mental health services available to minorities who appear before the court, which is critical to serving a multi-cultural city such as Toronto. The participant felt that culturally sensitive services would better support minority accused persons in dealing with the compound stigma of being a racial minority, coming into conflict with the criminal justice system and living with a mental illness. Concerns regarding a lack of cultural sensitivity are supported by the experience of individuals living with mental illness from minority groups who are often one of the most difficult populations to serve. That is, individuals from minority groups have complications from additional stressors associated with "migration and acculturation, language difficulties, socioeconomic disadvantage, inadequate housing, lack of access to services, and discrimination" (Yang

et al., September 2005, p.1053). These minority groups are more vulnerable than non-minority individuals living with mental illness. Unfortunately, minorities living with mental illness are also found to be underserved by the 'mainstream mental health system' due to cultural and language barriers (Yang et al., September 2005).

In regards to the findings of my study, further research is required to determine the impact of the structural aspects of race, class and gender on the stigmatization of individuals living with mental illness and their experience in the Toronto Mental Health Court. By having a clearer understanding of the impact these structures have on the accused appearing before the court, changes can be made to more strongly support this vulnerable population.

Recommendations

The findings of my study lead to the conclusion that stigmatization of an accused is present in the structure and functioning of the Toronto Mental Health Court. In an effort to reduce the negative impact of stigmatization on the accused I suggest three recommendations which the court should take into consideration. The first two recommendations relate to the functioning of the Toronto Mental Health Court. First, the presence of stigma was found in the court's functioning through the behaviour of court employees: in their interaction with the accused, in their consultation with other court employees regarding accused and in the terminology which they use to describe accused who appear before the court. In order to reduce stigma, I recommend that the Toronto Mental Health Court provide education and training on mental health to all of its personnel including external defense counsels who work in the court on a less regular basis.

A study completed by researchers at Kent University provides evidence that education is an effective tool in reducing stigmatization of individuals living with mental illness. This study compared the difference between the opinion of police officers who received crisis intervention training and those who had no crisis intervention training with regard to their conceptions of mental illness and their interaction with individuals living with mental

illness. The study found that officers who did not receive training desired more social distance from individuals living with mental illness and had higher perceptions of dangerousness than those officers who were trained and educated in mental illness (Kent University: Sociology Department, July 2005). As such, education could be used as an effective tool in reducing the stigma related to mental illness in the functioning of the Toronto Mental Health Court.

The second recommendation that the Toronto Mental Health Court should take into consideration in reducing stigmatization and improving support for the accused, is for the court to build closer relationships with local community mental health organizations. As discussed in the result of the court's functioning, it was difficult to find participants from external community agencies to take part in this research. In several instances, agencies with staff that were involved with the mental health court stated that they were not sufficiently involved and did not feel that their staff had enough knowledge to contribute to the study. Although the court has a good relationship with mental health court support workers employed by CRCT, I believe that it would be beneficial to develop stronger ties with other community resources. By developing stronger relationships and educating community mental health resources about the operations and purpose of the Toronto Mental Health Court, court personnel may not encounter as much difficulty in accessing support for the accused.

The third recommendation is aimed at reducing stigma found in the structure of the Toronto Mental Health Court. To decrease the negative impact of labeling that the accused experience, changes would have to go beyond the scope of the Toronto Mental Health Court. Over the years, the media has largely provided negative portrayals of individuals living with mental illnesses, which results in widespread discrimination against those affected by these illnesses. It is society's perceptions of mental illness, which contribute to the negative labeling of accused who appear before the mental health court. As such, to decrease the negative impact of labeling, stigmatization would have be considered on a more macro level and education should be provided to the general

population in order for them to change their perspective on mental illness and stigmatization in the structure of the mental health court.

Appendix A: Summary of Study

Since the establishment of the Mental Health Court in May 1998, it appears that nothing has been published on the impact this specialized court has had on individuals suffering from mental illness who come into conflict with the law. My study will examine the relationship between stigma and mental illness. For the purpose of my study, stigma will be referred to as the label or negative stereotype (i.e. abnormal or dangerous) attached to an individual based on their illness. As a result those people who carry this label suffer discrimination. The goal of my study is to examine whether the Mental Health Court through its structure and operations has an impact on the stigmatization of individuals suffering from mental illness. I will examine this through completing qualitative interview with employees who work within the Mental Health Court as well as with professionals who advocate on behalf of individuals appearing before the court. I am proposing to conduct a semi-structured interview that will take up to 45 minutes in length at a location and time convenient to you.

The interview will focus on your role as an advocate for individuals suffering from mental illness that come into contact with the mental health court. Specifically, your perception of how the mental health courts works, what the mental health court attempts to achieve, and your perception of the relationship between stigma and individuals who appear before the court.

Appendix B: Letter of Recruitment for Community Service Agencies

Dear_____

My name is Samantha Ghandour and I am a Master of Social Work candidate at Carleton University, conducting research on the Toronto Mental Health Court. This study is the basis of my thesis. The research project is under the supervision of Professor Allan Moscovitch.

Since the establishment of the Mental Health Court in May 1998, it appears that nothing has been published on the impact this specialized court has had on individuals suffering from mental illness who come into conflict with the law. My study will examine the relationship between stigma and mental illness. For the purpose of my study, stigma will be referred to as the label or negative stereotype (i.e. abnormal or dangerous) attached to an individual based on their illness. As a result those people who carry this label suffer discrimination. The goal of my study is to examine whether the Mental Health Court through its structure and operations has an impact on the stigmatization of individuals suffering from mental illness. I will examine this through completing qualitative interviews with employees who work within the Mental Health Court as well as with professionals who advocate on behalf of individuals appearing before the court. I am proposing to conduct a semi-structured interview the will take up to 45 minutes in length at a location and time convenient to you.

The interview will focus on your role as an advocate for individuals suffering from mental illness coming into contact with the Mental Health Court. Specifically, your perception of what the Mental Health Court attempts to achieve and your perception of the relationship between stigma and individual that appear before the court.

Your participation is voluntary and your identity will remain anonymous unless you give explicit permission to be quoted directly. There is no perceived risk associated with participating in this study as you have the right to refuse to answer any questions and may end the interview at any time. Should you decide not to continue the interview, it is at your discretion whether I can use the information provided. With your permission, I would like to tape record the interview. If this is not agreed upon I will take written notes during the interview. The information will be kept in a secure location that only I can access. Tapes will be destroyed. As the principal researcher, I as well as the professional transcriber will have access to the data. The professional transcriber will sign a statement of confidentiality. The transcripts and notes will be stored with me for my own future research.

You can contact me at anytime, Samantha Ghandour (Principal Researcher, at sghandour_@hotmail.com or (613) 859-4740). You can also contact Professor Allan Moscovitch (Thesis Supervisor, at 613-520-2600 ext.8919). Should you have an ethical or other concern regarding this study please contact the Carleton University Research Ethics Committee (613-520-2517, or email the committee coordinator at ethics@carleton.ca).

Please note that the results of this study will be made public in my Master's thesis. Data from interviews will be presented in an aggregate form unless I have explicit permission to quote from participants' responses. If you are interested in obtaining the results, please contact me for a summary of my findings, or for access to the thesis itself.

Your time and assistance with this study is greatly appreciated.

Samantha Ghandour

Appendix C: Informed Consent

Consent Form for Participants: Study of the Toronto Mental Health Court

I _____ have been asked by Samantha Ghandour, a Master of Social Work Student at Carleton University, to participate in a research study on Stigmatization and the Toronto Mental Health Court. I understand that Ms.Ghandour is under the academic supervision of Professor Allan Moscovitch.

I understand that I will be participating in a semi-structured interview that will take up to 45 minutes in length. The interview will focus on my roles with the Mental Health Court, my perspective of the operations of the Court and my perception of the relationship between stigma and accused that appear before the court. I understand that there is no perceived risk associated by participating in this study.

I understand that my participation is voluntary. I understand that my identity will remain anonymous unless I give explicit permission to be quoted directly. I have the right to refuse to answer any questions and end the interview at any time. If I chose to end the interview, I will decide at that time if the researcher may use the information I have provided.

___ I agree to be tape-recorded. I understand that the tapes will be destroyed once they have been transcribed.

___ I do not wish to be tape-recorded. The researcher will only take hand written note during the interview.

I understand that the principal researcher will be the only person to have access to the notes and that a professional transcriber will do transcripts of the interviews. All transcripts and notes will be stored for future research by the researcher for the purpose of completing a thesis meeting the requirements of the Master of Social Work and for the purpose of completing subsequent academic publications, workshops and conferences based on the thesis. If used for other topics my consent will be sought. I am aware that the results of my interview will be revealed in the thesis. I am aware that data from interviews will only be presented in an aggregate form unless I give explicit permission to quote from participants' responses.

I have had the opportunity to have any question regarding the study to the researched. My signature indicates that I agree to participate. I understand that the Carleton University Research and Ethics Committee has been approved this project

If I have any additional questions about the research project I may contact the researcher or her supervisor:

Researcher:

Samantha Ghandour
sghandour_@hotmail.com
(613) 859-4740

Supervisor:

Prof. Allan Moscovitch
AllanMoscovitch@carleton.ca
School of Social Work
Carleton University
1125 Colonel By Drive
Ottawa, ON K1S 5B6
(613) 520-2600 ext. 8918

Any concerns I may have about the project and the conduct of the researcher are to be reported to the ethics committee.

Prof. Antonio Gualtieri, Chair
Research Ethics Committee
511A Tory Building
Carleton University
1125 Colonel By Drive
Ottawa, ON K1S 5B6
Tel: 613- 520-2517
Email: ethics@carleton.ca

Participant's signature: _____
Date: _____
Researcher's Signature: _____
Date: _____

Appendix D: Interview Guidelines

Interview Guideline (Employees of the Court)

Part 1: Identification Questions

Question 1: Name

Question 2: What is the work that you do at the Mental Health Court?

Question 3: When did you start working in the Mental Health Court?

Question 4: Can you tell me what you do in the Court? How do you do this?

Question 5: Do you have experience working with individuals suffering from mental illness, prior to working in the Mental Health Court? Would you please describe your experience?

Professional Opinion Questions

Part 2: Structure

Question 6: Can you describe the structure of the Toronto Mental Health Court? *(i.e. structure refers to a way to describe how the Toronto Mental Health Court is organized.)*

Question 7: What do you believe to be the purpose of the Mental Health Court?

Question 8: What problems do you believe the Court tries to solve?

Question 9: What are some positive aspects of the Mental Health Court?

Question 10: What are some of the limitations that the Mental Health Court faces?

Question 11: To your knowledge, what are the major reasons why an individual appears before the mental health court?

Part 3: Functioning
(The word functioning will be used to describe how people who work in the Mental Health Court operate it on a daily basis.)

Question 12: From your experience can you describe a typical day in the mental health court?

Question 13: What are some of the challenges that you face working in the court?

Question 14: What are some of the rewarding aspects of working in the mental health court?

Question 15: Do you work with other agencies that advocate on behalf of accused? If so, which agencies? In what way?

Question 16: How frequently do you work with organizations that are outside of the Mental Health court structure?

Part 4: Stigma

Question 17: What does the term stigma mean to you?

Question 18: Is stigma a factor which your clients encounter? Is so, how does it occur?

Question 19: Is it in the structure of the Mental Health Court to address issues of stigma and negative labeling?

Question 20: Have you ever seen the stigmatization of an accused appearing before the court?

A) If so, who was doing the stigmatizing?
B) How did this occur?

Question 21: In what way do you think the Mental Health Court has an impact on the stigmatization of individuals that suffer from mental illness?

Case Scenario will only be asked on participants that work in the Mental Health Court

Case Scenario One:

A 35 year-old gentleman is appearing before the court. He is disheveled, unshaven and has been living in the Salvation Army men's shelter prior to his charges. He is currently in custody at the Don Jail awaiting a bail hearing on harassment charges. The gentleman was sent to the Mental Health Court because he has a history of psychiatric treatment.

Based on the Scenario can you please answer the following questions (*Questions 22-25 are related to Case Scenario One)*

Question 22: Would you describe this as a typical scenario of an individual brought before the court? If yes why? If no why not? What do you want to know? Whether this type of case is possible?

Question 23: What are some of the different alternatives that the court could present to this individual?

Question 24: If you had to predict, what do you think would happen to this individual in the Mental Health Court system?

Question 25: Referring to the answer you have just given, how would they do that?

Case Scenario Two:

An 18 year-old woman appears before the mental health court accused of theft under $1000. This young woman is charged with stealing $100 dollars worth of makeup from the local drug store. She appears very anxious and very tearful. She was unable to answer questions during her last appearance in court. She had been directed to the Mental Heath Court with concerns regarding her fitness to stand trial.

Based on the Scenario can you please answer the following questions (*Questions 26 – 29 are related to Case Scenario Two)*

Question 26: Would you describe this as a typical scenario of an individual brought before the court? If yes why? If no, why not? What do you want to know? Whether this type of case is possible?

Question 27: What are some of the different alternatives that the court could present to this individual?

Question 28: If you had to predict, what do you think would happen to this individual in the Mental Health Court system?

Question 29: Referring to the answer you have just given, how would they do that?

Interview Guideline (Representatives from Community Agencies)

Part 1: Identification Questions

Question 1: Name

Question 2: What organization do you work for?

Question 3: How long have you worked there?

Question 4: How did you learn about the Mental Health Court?

Question 3: How have you worked with the Court?

Question 4: Can you tell me the role that you play with the Court? How do you do this?

Question 5: Do you have experience working with individuals suffering from mental illness, prior to working with clients involved with the Mental Health Court? How many years?

Professional Opinion Questions

Part 2: Structure

Question 6: Can you describe the structure of the Toronto Mental Health Court?
(I.e. structure refers to a way to describe how the Toronto Mental Health Court is organized.)

Question 7: What do you believe to be the purpose of the Mental Health Court?

Question 8: What problems do you believe the Court tries to solve?

Question 9: What are some positive aspects of the Mental Health Court?

Question 10: What are some of the limitations that the Mental Health Court faces?

Question 11: To your knowledge, what are the different circumstances why an individual appears before the mental health court?

Part 3: Functioning
(The word functioning will be used to describe how people who work in the Mental Health Court operate it on a daily basis.)

Question 12: From your experience can you describe a typical day in the mental health court?

Question 13: What are some of the challenges that you face working in the court?

Question 14: What are some of the rewarding aspects of working in the mental health court?

Question 15: Do you work with other agencies that advocate on behalf of accused? If so, which agencies? In what way?

Question 16: How frequently do you work with organizations that are outside of the mental health court structure?

Part 4: Stigma

Question 17: What does the term stigma mean to you?

Question 18: Is stigma a factor which your clients encounter? Is so, how does it occur?

Question 19: Is it in the structure of the Mental Health Court to address issues of stigma and negative labeling?

Question 20: Have you ever seen the stigmatization of an accused that appears before the court?

A) If so, who was doing the stigmatizing?
B) How did this occur?

Question 21: In what way do you think the Mental Health Court has an impact on the stigmatization of individuals that suffer from mental illness?

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