THE SENTENCING PROJECT

Mentally Ill Offenders in the Criminal Justice System:
An Analysis and Prescription

The Sentencing Project

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FOREWORD

At the beginning of the new century, the United States is the world leader in incarceration, with a higher proportion of its population behind bars than any other country. This distinction is primarily the result of policy decisions, in many areas and at various levels of government, and not rising crime rates. Incarceration has not proven to be the most effective strategy in reducing crime, and brings with it significant financial and social costs.

In response to this situation, The Sentencing Project is investigating sentencing, court and corrections options for specific groups of offenders which are contributing to the burgeoning prison and jail population. For many of these groups – including offenders who are children, elderly, mentally ill, learning disabled, or terminally ill – there exist alternative approaches – "a better way" – within and outside the criminal justice system that are more effective and less costly.

This report, an analysis of the "criminalization" of people with mental illness and its impact on the criminal justice system, is the result of work by The Sentencing Project's Campaign for an Effective Crime Policy. The Campaign was initiated in 1992 as a national effort of concerned criminal justice officials who issued "A Call for a Rational Debate on Crime and Punishment." The Call was subsequently endorsed by more than 1,400 criminal justice officials and policymakers throughout the country, and the Campaign produced a series of policy reports analyzing trends in the justice system and proposing recommendations for more effective public policy. The Campaign's functions have now been incorporated within The Sentencing Project. The purpose of the information and recommendations presented in this report is to inform the public debate and to be of use to criminal justice practitioners and state and local policymakers who are working to improve the effectiveness of government services.

The Bureau of Justice Statistics has reported that 283,800 individuals with mental illnesses were confined in U.S. jails and prisons in 1998.[1] Overall, 16% of all inmates self-reported current mental illness or an overnight stay in a mental hospital, and an additional 14% had received other mental health services in the past. Almost one quarter of incarcerated women were identified as mentally ill. Of the ten million adults booked into local jails each year, approximately 700,000 have active symptoms of serious mental illness, and most of those have co-occurring substance abuse disorders.

Significant as these numbers are, many mental health experts believe they understate the problem due to under-reporting by people who might not want to disclose the information or are unaware of their illness.[2] Clearly, the "criminalization"[3] of people with mental illnesses is a phenomenon affecting many thousands of individuals and their families, as well as those who work within law enforcement, the courts and corrections systems, and mental health and substance abuse service providers.

This report will examine why so many people with mental illness are caught up in the criminal justice system and the effects this has on them and on the system. We also offer recommendations for changes in services, policies and practices to be implemented at each stage of the justice system -- from first police contact through release from prison -- to promote better outcomes both for individuals and the community as a whole. These include program models currently being implemented in various jurisdictions. The recommendations are focused on limiting the number of mentally ill people who are brought into the criminal justice system while providing better treatment and links between prison and community services for those who are incarcerated. In short, to offer a better way than reliance upon the institutions of punishment to address mental health problems.

Recommendations for changes include:
- Expanded and improved community services.
- Integration of systems to meet the needs of people with mental illness and other co-occurring disorders.
- Training for police to improve initial response to contacts with the mentally ill.
- Increased diversion from the criminal justice system for people with mental illness.
- Improvements in correctional mental health services for those who cannot be diverted.
- Pre-release planning for transition from prisons and jails back into the community with appropriate medical and support services.

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[1] P.M. Ditton, *Mental Health and Treatment of Inmates and Probationers*, July 1999, Bureau of Justice Statistics, US Department of Justice.

[2] Fox Butterfield, "Experts Say Study Confirms Prison's New Role as Mental Hospital," *The New York Times*, July 12, 1999.

[3] The term "criminalization of the mentally ill" refers to the increased likelihood of people with mental illness being processed through the criminal justice system instead of through the mental health system.

THE RISING NUMBER OF MENTALLY ILL PERSONS BEHIND BARS

The Population Shift from Psychiatric Hospitals to Prisons

In 1972, state and federal prisons in the United States held 200,000 people. Since then the prison population has experienced an unprecedented rise. By 2000, more than a million additional people had been added to the nation's prisons for a total of nearly 1.4 million, or nearly seven times the number of three decades ago. With an additional 620,000 people in local jails, the total number of people behind bars reached over 1.9 million and was predicted to reach 2 million by the end of 2001.[4]

State mental hospital populations peaked at 559,000 persons in 1955. By contrast, 70,000 individuals with severe mental illnesses are housed in public psychiatric hospitals today, 30% of whom are forensic patients remanded by the courts.

Forty state mental hospitals have closed during the past decade while more than 400 new prisons have been opened. As a result, jails and prisons have become the institutions most likely to house the mentally ill.

- In the early 1970s, Michigan's mental institutions held about 28,000 patients, while its prisons held 8,000 inmates. Today there are fewer than 3,000 patients in Michigan mental hospitals, while the state's prisons hold more than 45,000 inmates.

- Los Angeles County Jail, reputed to be the largest *de facto* mental institution in the United States, holds an estimated 3,300 seriously mentally ill inmates on any given night.[5]

- In 1997, 15,000 inmates were treated for serious mental illness in New York City's jail on Riker's Island.[6]

- The Cook County Jail holds the largest number of institutionalized mentally ill people in Illinois, where 1,000 of the 11,000 people confined have been identified as mentally ill.[7]

- In Florida, mentally ill inmates in jail and prison outnumber patients in state mental hospitals by nearly five to one. In November 1999, state mental hospitals held 2,671 patients, while county jails housed 5,300 individuals with mental illnesses, and state prisons an additional 6,800.[8]

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[4] A.J. Beck, and J.C. Karberg, *Prison and Jail Inmates at Midyear 2000*, March 2001, Bureau of Justice Statistics, US Department of Justice.
[5] *Sacramento Bee*, "Treatment, Not Jail: A Plan to Rebuild Community Mental Health," March 17, 1999.
[6] Heather Barr, *Prisons and Jails: Hospitals of Last Resort*, The Correctional Association of New York and The Urban Justice Center, 1999.
[7] Mark J. Heyrman, "Mental Illness in Prisons and Jails," *Roundtable*, Volume 7, The University of Chicago Law School, 2000.
[8] Debbie Salamone Wickham, "Society Criminalizes Their Mental Illness," *Orlando Sentinel*, October 31, 1999.

<u>Driving Forces of the Population Shift</u>

Prisons and jails have always held people who are mentally ill. Given the dramatic rise in the overall incarcerated population, it could have been expected that the number of incarcerated mentally ill persons would have risen. However, other factors have brought the proportion of mentally ill within the criminal justice system to a vastly higher level than their proportion within the general population. Mental disorders among prisoners are estimated to be at least five times more prevalent than in the general population.[9] Much of the problem has arisen from deliberate policy decisions and can therefore be remedied by changes in policies and procedures.

<u>Untreated Mental Illness in the Community</u>

The number of mentally ill people in the community who are not receiving adequate treatment has increased as a result of deinstitutionalization without a corresponding development of community-based mental health services. At the same time additional restrictions have been placed on involuntary commitment.

- *Deinstitutionalization* – The deinstitutionalization of state mental hospital populations, beginning in the 1960s, developed in response to a number of factors: legal advocacy on behalf of people "warehoused" in state mental hospitals, in some cases for a lifetime; the development of more effective psychotropic medications promising better symptom control; and federal legislation establishing "Community Mental Health Centers" to help released patients establish new lives in caring communities. In response, state governments dramatically accelerated the release of patients and the "downsizing" of state mental hospitals during the 1970s and 80s.

  The transfer of former hospital patients to community care represented an important effort to provide new opportunities for integration in community life, as well as more humane and cost-effective care for people with mental illnesses. Unfortunately, planning was flawed and implementation uneven. One major problem was the failure to anticipate and address the "Not In My Back Yard" syndrome that soon developed in many communities. In some places, local neighborhood organizations fought attempts to establish group homes. Local mental health systems struggled to provide an adequate array of services, but were generally unprepared to meet the basic needs of a population that had long been dependent on institutional care. Due in part to communities' lack of preparedness and resources, the needs of many of the deinstitutionalized mentally ill have not been met. As a result, growing numbers of released patients drifted toward life on the streets and many of the mentally ill have ended up exchanging hospitalization for institutionalization in prison or jail.

- *Reductions in Treatment Spending and Availability* – While treatment enables many people with serious mental illnesses to function effectively in community life, access to treatment and other essential services often falls short of the need. Barriers to treatment include fragmentation of treatment services (mental illness, substance abuse, general medical care),

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[9] Terry Kupers, M.D., *Prison Madness*, Jossey-Bass, 1999, p. 11.

homelessness, lack of transportation and difficulties in accessing key government-funded health coverage and income supports.

State governments have traditionally been the major funders for public mental health services, and remain so today. But according to the Bazelon Center for Mental Health Law, total state spending for treatment of the seriously mentally ill is one third less now than in the 1950s.[10] According to a 1998 study by the Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration, a comprehensive analysis of nationwide spending on mental health, alcohol and drug abuse treatment services found that the growth of spending for the treatment of mental illness and substance abuse has been lower than for health care generally.[11]

Long-term hospitalization in private mental health facilities has also declined due to cost increases, restrictions on insurance coverage for mental illness, and time-limits imposed by insurers on length of in-patient treatment.

- *Barriers to Involuntary Commitment* – Families and others seeking to force the mentally ill into treatment are faced with changes in mental health law that have made involuntary commitment more difficult. Most state mental health codes require psychiatric hospitals to show clear and convincing evidence that patients being committed involuntarily are either a danger to themselves or others or are so gravely disabled by their illnesses that they are unable to care for themselves. People cannot be hospitalized against their will without legal representation and a full judicial hearing.

Some critics of these laws have called for a relaxation of commitment standards so that the untreated mentally ill can be returned to hospitals. However, laws regarding both involuntary treatment and involuntary commitment are controversial and advocacy groups and service providers working on behalf of the mentally ill are deeply divided on them (see box on next page).

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[10] The Bazelon Center for Mental Health Law, *Position Statement on Involuntary Commitment*, 1999.
[11] Substance Abuse and Mental Health Services Administration (SAMHSA), *Press Release*, Sept. 15, 1998, p. 2.

Involuntary Treatment and Civil Commitment:
Policy Perspectives

Few issues in the field are more controversial than involuntary treatment and civil commitment of people who refuse medication. For example:

According to the **Treatment Advocacy Center**, approximately 40% of all individuals with severe mental illnesses are not receiving treatment at any given time. Many are homeless, in jail on misdemeanor charges, and "responsible for increasing episodes of violence." A major reason is that "because of the effects of the illness on their brain, they lack awareness of their illness…. Such individuals consistently refuse to take medication because they do not believe they are sick. In most cases, they will take medication only under some form of assisted treatment." The Center strongly supports a policy of mandatory treatment when indicated, citing "violent crimes committed by delusional individuals who might not have lashed out if they had been detained and forcibly medicated."[*]

The **Bazelon Center for Mental Health Law** opposes involuntary *inpatient* civil commitment except in response to an emergency, and then only when based on a standard of imminent danger of significant physical harm to self or others and when less restrictive alternatives are unavailable. The Center also opposes all involuntary *outpatient* commitment as an infringement of an individual's constitutional rights and supports the right of each individual to fully participate in, and approve, a treatment plan and to decide which services to accept. "The threat of forced treatment, with medication that has harmful side effects, often deters individuals from voluntarily seeking treatment. At best, outpatient commitment undermines the therapeutic alliance between the provider and consumer of mental health services."[**]

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[*] Treatment Advocacy Center, "Assisted Outpatient Treatment Will Help Reduce Preventable Episodes of Violence, Homelessness and Incarceration" in New York, May 19, 1999.
[**] Op. cit., The Bazelon Center for Mental Health Law.

<u>Criminalization of Mental Illness</u>
Police, courts and legislatures have adopted an increasingly punitive approach to the treatment of people who do not fit within societal norms. Policies such as "zero tolerance" policing, mandatory sentences that carry harsh penalties for drug offenses, and restrictions on access to support systems such as welfare are all reflections of a punitive, rather than problem-solving, approach which has led to the criminalization of the mentally ill.

Criminalization implies that people are being inappropriately processed through the criminal justice system rather than through the mental health system. However, if people with mental illness commit serious violent crimes, then a criminal justice response may be necessary in order to preserve public safety. Studies suggest that the crimes committed by the mentally ill fall under three broad categories:

- Illegal acts which are a byproduct of mental illness; e.g., disorderly conduct, criminal trespass, disturbing the peace, public intoxication.
- Economic crimes to obtain money for subsistence; e.g., petty theft, shoplifting, prostitution.
- More serious offenses such as burglary, assault and robbery.

Offenses in the first two categories might be avoided, or at least reduced, by better community resources providing treatment and other support services. Crimes in the third category are likely to continue to involve the criminal justice system. However, the mentally ill in prisons and jails need treatment and services to ensure that their condition is not exacerbated by imprisonment. They also require specialized prerelease planning to ensure a successful transition back into the community.

The "revolving door" between jail and the street is propelled largely by untreated mental illness and co-occurring substance abuse disorders among individuals who have committed relatively minor crimes. This population includes homeless and mentally ill people whose untreated mental illnesses lead to repeated "nuisance crimes" and jail.

People with mental illness are more likely to exhibit the kinds of behaviors that will bring them into conflict with the criminal justice system, particularly under current policies of "zero tolerance" and arrests for "quality of life" crimes. According to the Bureau of Justice Statistics prisoners with mental illnesses were twice as likely as other inmates to have been homeless prior to their arrest; forty percent were unemployed; and nearly half said they were binge drinkers.[12]

Many people who suffer from both mental illness and substance abuse (referred to as co-occurring disorders) are particularly at risk of incarceration. Estimates of the proportion of people with mental health disorders who also have a substance abuse disorder range between 25-50%.[13] Almost 60% of mentally ill state prisoners reported using drugs in the month before their arrest.[14]

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[12] Ditton, op. cit.
[13] The National GAINS Center, *Treatment of People with Co-Occurring Disorders in the Justice System.*
[14] Ditton, op. cit.

Co-occurring disorders in particular are strongly associated with poor social functioning, homelessness, violence, arrest and incarceration.[15] The population of individuals with substance abuse problems as well as mental illness is considered hard to serve and is chronically underserved in most communities. Some providers are unwilling or unable to work with persons whose illnesses are so difficult to manage. Hospital emergency rooms, homeless shelters and jails are often used as *de facto* service centers for troubled, indigent and vulnerable mentally ill/substance-abusing individuals. An overloaded system and the lack of adequate treatment resources for co-occurring mental illness and substance abuse disorders have severely restricted many individuals' access to treatment, increasing the likelihood of offending and incarceration of these individuals.

While some of the more serious offenses committed by the mentally ill may be driven by the same factors that lead people without mental illness to commit crime, some violent acts may be attributable to untreated mental illness. About 53% of inmates with mental illnesses in state prison have been convicted for a violent offense, compared to 46% of other inmates. Among mentally ill jail inmates, 30% were charged with a violent offense, compared to 26% of other inmates.

Attitudes toward Mental Illness and Violence

Public perceptions of the dangerousness of mentally ill people and doubts about the use of insanity pleas have encouraged policies that blur the boundary between treatment and punishment.

- *The link between mental illness and violence* – Some of the more punitive approaches to the mentally ill are driven by fear of their potential to commit violence. This fear has been fueled by recent sensational and widely-reported violent attacks such as the shooting of two guards inside the U.S. Capitol. The relationship between mental illness and criminal behavior has been extensively studied.[16] Older studies were conducted on institutionalized populations but more recent ones have looked at those discharged from hospitals and compared them to the general population. (See inset, page 10). These studies have found a statistically significant relationship between mental illness and violence. However, the link of mental disorders to violent behavior is not based on a diagnosis of mental illness but on current psychotic symptoms,[17] and can be mitigated through appropriate medication and treatment. Violent behavior is most likely to occur when people with mental illness have a co-occurring substance abuse problem. Alcohol and drug abuse also raise the likelihood of violence by the non-mentally ill, but to a lesser extent. However, the contribution of mental illness to overall levels of violence in the United States is considered to be very small. One estimate is that the seriously mentally ill commit 4% of all homicides.[18] The misunderstanding of the level of violence among mentally ill persons contributes to a

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[15] The National GAINS Center, op. cit.

[16] For a review of many of these studies and a summary of their results, see Arthur J. Lurigio, "Changing the Contours of the Criminal Justice System to Meet the Needs of Persons with Serious Mental Illness," and James A. Swartz, in *Criminal Justice 2000*, Volume 3.

[17] National Institute of Justice Research Preview, *Mental Illness and Violent Crime*, October 1996.

[18] E. F. Torrey, *Out of the Shadows: Confronting America's Mental Illness Crisis*, Wiley & Sons, 1997.

climate of fear in which confrontational police tactics, intervention of the criminal justice system and prolonged periods of incarceration are seen as acceptable, even necessary, steps.

- *"Guilty but Mentally Ill" Laws* – Use of the insanity defense has been increasingly under attack, particularly since John Hinckley was found not guilty by reason of insanity for the attempted assasination of President Reagan in 1982. The perception that mentally ill people were "getting away with crime" by hiding behind their claims of illness has resulted in 13 states adopting "guilty but mentally ill" laws. These laws allow for the finding of mental illness but still impose the same sentence as would have been given to someone who was not ill. Although these laws may make provision for some treatment during the period of incarceration, their main purpose is to elevate the principle of retribution above that of treatment.

Lack of Pre-Release Planning and System Integration
Lack of coordination between systems results in people who have been incarcerated leaving prison or jail without any connection to support services such as community agencies or federal entitlement programs to provide health coverage or money to live on.

Once the mentally ill are within the criminal justice system, their condition may deteriorate as a result of inadequate treatment and because the circumstances of life behind bars are likely to exacerbate their condition. For example, the overcrowding that is endemic in prisons today leads to greater levels of violence, a lack of privacy, excessive noise, and other stressful conditions that are hard on everyone but particularly so on those subject to emotional and psychiatric problems. When they leave prison or jail, if no appropriate arrangements are made for treatment and services on the outside, they are likely to return to the lifestyle and disruptive behavior that brought them into the system in the first place and the cycle will be repeated.

This issue has been the subject of litigation filed by the Urban Justice Center on behalf of mentally ill inmates discharged from the New York City jail system. The lawsuit contends that of the 30,000 inmates who have received treatment for mental illness who are discharged from the city's jail system only 7% have received any discharge planning. The remaining 93% are either released from court or dropped off at a subway station between 2 a.m. and 6 a.m. with two subway tokens and $1.50 in cash. Individuals who were on psychotropic medication while in jail are not given a supply of medication, nor are mentally ill inmates given referrals to Medicaid, SSI, housing, or other supportive services. In March 2001, the Appellate Division of the State Supreme Court required the city to provide ongoing mental health services to inmates until the lawsuit is decided.

The MacArthur Research Network on Mental Health and the Law conducted a *Violence Risk Assessment Study,* to determine which former psychiatric hospital patients would be considered dangerous. It followed 1,000 people between the ages of 18 and 40 for one year after discharge, interviewing them and at least one person who was most familiar with their behavior in the community, every ten weeks. Researchers also examined police and hospital records.

The study classified approximately three quarters of the patients they assessed into one of two risk categories: "High violence risk" patients were defined as being at least twice as likely as the average patient to commit a violent act within the first 20 weeks following hospital discharge. "Low risk" patients were defined as being, at most, half as likely as the average patient to commit a violent act within the first 20 weeks following hospital discharge. Over a year's time, researchers estimated the occurrence of violence to others in the community based on patients' self-reports, reports of family members, arrest records and mental hospital records.

Researchers found that 18.7% of all patients committed at least one violent act during the first 20 weeks following hospital discharge. "High violence risk" patients had a 37% likelihood of being violent, while "low violence risk" patients had, at most, a 9% chance.

In order to address the question of how the rate of violence by other members of the community compares with the rate of violence by former mental patients, researchers conducted a *Community Violence Risk Study* in three sites. Five hundred adults between the ages of 18 and 40 living in the same neighborhoods in which the former patients resided were recruited as subjects. Measures for estimating the occurrence of violence to others included patients' and families' self-reports, arrest records and mental hospital records.

Findings include the following:

➢ People diagnosed with a major mental disorder and without a substance abuse diagnosis are involved in significantly less community violence than people with a co-occurring substance abuse diagnosis.

➢ The prevalence of violence is higher among people – discharged psychiatric patients or non-patients – who have symptoms of substance abuse. People who have been discharged from a psychiatric hospital are more likely than other people living in their communities to have symptoms of substance abuse.

➢ The prevalence of violence among people who have been discharged from a psychiatric hospital and who have symptoms of substance abuse is significantly higher than the prevalence of violence among other people living in their communities who have symptoms of substance abuse, for the first several months after discharge.

➢ When people discharged from a mental hospital turn violent, they will typically strike a family member in their own home, not unlike the violence committed by other people living in their communities.

The MacArthur Violence Risk Assessment Study, Executive Summary, updated April 2001. Available online at http://www.macarthur.virginia.edu/risk.html

Many low-income and indigent individuals with disabling mental illnesses rely upon federal entitlements for income support, medications and mental health care in the community. These benefits are terminated when mentally ill individuals land in jail. Under current federal law, Medicaid funds cannot be used to pay health care providers for health care costs of incarcerated individuals. While federal law does not require state or local governments to terminate benefit eligibility for these individuals, many states and localities terminate inmate eligibility for Medicaid, Supplemental Security Income and other entitlements such as Social Security Disability Insurance (SSDI) when mentally ill individuals are released from jail. As a result, many former inmates must reapply for benefits upon release to the community, a process that can take weeks or months. The long wait for a Medicaid card is particularly problematic, since it is often the only means of obtaining mental health services and treatment of co-occurring mental health and substance abuse disorders. The potential for recidivism can reasonably be expected to increase under such circumstances. And, due to their indigent condition, released individuals with mental illnesses are likely to constitute a cost to the county, without the federal assistance to which the county is entitled. Local social services can also be hard to access, due to lack of transportation and difficulty in dealing with the complexities of qualifying for aid.

DEVELOPING SOLUTIONS

The following section offers recommendations for steps that can be taken at each stage of the criminal justice system to limit the number of mentally ill persons coming into the system and to ensure optimal treatment and outcomes for those who do end up in jail or prison. However, the most important changes that are needed have a much wider focus. People with serious mental illness require a comprehensive community-based treatment approach that provides essential services, ensures public safety and reduces recidivism in criminal justice institutions.

While law enforcement, criminal justice and correctional officials increasingly recognize the need to work closely with mental health, substance abuse, and social service practitioners to address the special needs of people with mental illnesses and co-occurring disorders, the necessary resources are generally not available. As a result, large numbers of people with mental illnesses and substance abuse disorders are repeatedly recycled through jails and prisons, providing little if any benefit to the individual or the community.

One major problem arises from the splintered nature of many of the mental health and treatment options that are provided. Many psychiatric programs are designed to treat either the mentally ill or the developmentally disabled, or people with a chemical dependency. Many substance abuse programs do not accept people with mental illness. As a result, many people with multiple conditions, who constitute a large percentage of the mentally ill within the criminal justice system, are precisely the group who find it hardest to obtain appropriate treatment in the community. They also present a particular problem for police who are called to incidents involving people with more than one problem as they are often faced with no alternative but arrest. For example, mental health centers often decline to treat alcoholics, drug treatment programs find the mentally ill too disruptive and so refuse them entry, and emergency rooms are often unwilling to treat the mentally ill who are intoxicated or threatening. So they end up by default in the local jail.

The main challenge in the effort to build more effective community based service systems is to overcome political and agency inertia. A 1999 report from the Open Society Institute and the National GAINS Center outlined the need for system integration in communities to link mental health, substance abuse and criminal justice systems.[19] As the report acknowledged, "System integration …. [is] a powerful mechanism for communities to improve service delivery and to treat people, not just problems. System integration can benefit everyone. However, for integration to work, the old ways of doing things need to be challenged and new ways created. Integrated services that provide treatment, case management and housing serve the entire community's interests by reducing homelessness and public disturbances, as well as reducing inappropriate detention and the number of detainees, increasing treatment involvement, and breaking the cycle of decompensation, arrest and incarceration."[20]

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[19] Open Society Institute's Center on Crime, Communities & Culture, and the National GAINS Center, *The Courage to Change: A Guide for Communities to Create Integrated Services for People with Co-Occurring Disorders in the Justice System*, December 1999.
[20] Ibid.

Community Services

If lack of adequate community resources and services is one of the main reasons for the criminalization of the mentally ill, then the improvement of community services is obviously key to making systemic change. Diversion from the criminal justice system to civil or treatment systems must be designed to protect the community and the individual, and ensure ongoing treatment of people with co-occurring disorders. Diversion not only benefits the offender, but it can also help save money by lowering the recidivism rate of mentally ill offenders who frequently return to the system because their symptoms lead to continued arrests and incarceration. The Substance Abuse and Mental Health Services Administration (SAMHSA), described the intent and importance of diversion this way:

> *The best diversion programs see detainees as citizens of the community who require a broad array of services, including mental health and substance abuse treatment, housing, and social services. Diversion programs are often the most effective means to integrate an array of mental health, substance abuse and other support services to break the cycle of people who repeatedly enter the criminal justice system.*[21]

Community services are important at the beginning of the process to prevent the development of the crises that lead to law enforcement involvement, to provide alternatives to incarceration when problems arise, and to ensure support for people returning to the community from prison and jail.

Among the necessary steps:

➢ Develop community resources, particularly the availability and accessibility of emergency mental health services, to reduce the likelihood that persons with mental illnesses will come in contact with police and be arrested.

➢ Allocate funding for community-based alternatives to incarceration and increased capacity to deliver essential services to probationers and others with mental illnesses.

➢ Work closely with mental health consumers, families and advocacy groups to improve services, develop new initiatives and involve all relevant agencies.

➢ Develop a program of aggressive outreach to homeless mentally ill individuals in the community to assess needs, engage individuals in treatment and provide case management services. Recognize that co-occurring disorders are the norm and not the exception. Long-term housing support for homeless mentally ill offenders is a critical need.

➢ Encourage local Social Security district offices to work with jails and local community mental health programs to facilitate both the re-instatement of benefits as individuals leave jail or prison, and the filing of applications on behalf of individuals in correctional facilities who have serious mental illnesses and may be eligible for SSI or SSDI but are not currently on the rolls.

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[21] US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, *Jail Diversion Knowledge Development and Application Program*, 1999.

➢ Create awareness among community leaders that every state has a State Protection and Advocacy Agency that is mandated to protect and advocate for the rights of people with mental illnesses and investigate reports of abuse and neglect in facilities that care for or treat individuals with mental illnesses. These facilities may be public or private, including hospitals, nursing homes, community facilities, board and care homes, homeless shelters, jails and prisons.

Police Contact/Pre-Booking

Police are generally the first on the scene when a person with mental illness creates a disturbance or commits a crime. To some extent they have the discretion to determine the subsequent course of events – arrest, hospitalization or informal disposition – depending on their view of the severity of the disturbance, the behavior of the offender, and the resource options available to them.

In most jurisdictions, the police can in theory initiate emergency hospitalizations for people who are either a danger to themselves or others. In practice, however, this discretionary power is significantly restricted by the stringent legal criteria surrounding involuntary commitment, the unavailability of community-based treatment slots, the unwillingness of mental health facilities or emergency rooms to accept patients who are perceived as intoxicated or recalcitrant, and the time and bureaucratic procedures required for admission.

➢ The appropriate use of discretion also requires police officers to understand the problem they are faced with and how best to react. Police agencies should provide in-service training to enable officers to recognize the signs and symptoms of serious mental illness.

➢ Specialized police units, such as the Memphis Police Crisis Intervention Team (CIT), can provide an immediate response to a crisis involving mentally ill people. Officers in these units, who have been trained to interact with the mentally ill, focus on defusing potentially volatile situations by gathering relevant history, assessing medication information, and evaluating the individual's social support system.

➢ Where possible, the mentally ill should be diverted from the criminal justice system at the initial point of contact with law enforcement officers. Pre-booking diversion will only occur if police are provided with options other than placing mentally ill arrestees in jail, such as placement in an environment where individuals can be properly screened, diagnosed and treated:

• Pre-booking programs in Memphis, Tennessee, Multnomah County, Oregon and Montgomery County, Pennsylvania, intensively train police to handle calls involving individuals with mental health or substance abuse problems. Each site has a 24-hour crisis center with a no-refusal policy for persons brought in by police.

• In Hillsborough County, Florida, officials established a Crisis Center to which police can bring criminal offenders suspected of having serious mental illnesses. In a similar effort, Seattle has proposed a "no refusal" triage center that can be used by police officers as an alternative to jail booking for individuals with mental illness or chemical addictions.

Post Booking

Overall, diversion from jail and re-entry into the community should be the primary objective for people with mental illnesses whose arrests result from symptoms of their illnesses. Individuals with mental illnesses who have been arrested for less serious, non-violent crimes should be diverted from jail to community-based mental health programs whenever possible. People receiving appropriate treatment in the community generally have a better long-term prognosis and are less likely to return to jail for a similar offense.[22]

➢ When mentally ill people are arrested, the jail system should provide for their specific needs, beginning with a process for early screening, classification and referral. For example, a three-tiered screening system in Summit County, Ohio, consists of an initial evaluation of mental status by a booking officer, a cognitive function examination administered by a mental health worker, and an evaluation by a clinical psychologist.

➢ Facilitating the bail decision so that defendants spend their pre-trial time in the community or an appropriate facility other than jail will limit the mentally ill offender's time in a particularly stressful environment.

➢ Supervised pretrial release programs are needed to include involvement of all the relevant agencies, including both mental health and criminal justice practitioners, prosecutors, defense counsel and the courts, along with community service providers, the individual with mental illness, and his or her family.

➢ People arrested for misdemeanors should be diverted to appropriate mental health treatment centers. A post-booking diversion program should screen individuals who may be eligible for diversion; evaluate their eligibility; negotiate with prosecutors, defense attorneys, community-based mental health providers, and the courts to produce a disposition outside the jail in lieu of prosecution, or as a condition of a reduction in charges.

  • In Wicomico County, Maryland, the Maryland Community Criminal Justice Treatment Program's case manager works with a diversion candidate to develop a treatment plan. The plan is discussed with the Assistant State's Attorney, the public defender, and the judge assigned to the case. When all parties agree that diversion is appropriate, the judge places the case on the "stet" docket, which leaves it open for one year. The defendant is then released to the community to complete his or her treatment program.

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[22] Policy Research Associates, Inc., *Jail Diversion – Creating Alternatives for Persons with Mental Illnesses*, Del Mar, New York.

<u>Trial and Sentencing</u>

At sentencing hearings, judges and others involved in the court process need to be aware of the role that serious mental illness may have played in a person's current charges. Traditionally, mental illness is considered only if it is a salient feature of the case (i.e., if there is a question about insanity or fitness to stand trial). To ensure that this happens:

➢ The defense bar needs training on mental health issues, including:
- interviewing techniques.
- use of social worker and staff trained in mental health issues.
- practice of obtaining records and tracking down discharge summaries or physician's evaluations for a client with a mental health history.
- staff with familiarity with treatment issues, epecially medications and their various impacts.

➢ Mentally ill individuals need timely access to counsel, preferably attorneys who have experience in working with individuals with mental illnesses.

➢ Judges must have information on offenders' mental health status available to them so that they can make a determination regarding: the defendant's competence to stand trial; whether medication is needed in order to achieve competency; the viability of developing specific plans to address offenders' mental health needs and establish referral mechanisms.

➢ State criminal codes should authorize or permit judges to divert non-violent offenders with mental illness away from incarceration to appropriate treatment, including the authority for judges to defer entries of judgment pending completion of treatment programs and to dismiss charges and expunge records of individuals who successfully complete treatment programs.

➢ Jurisdictions can establish sentencing alternatives for mentally ill offenders. The Nathaniel Project in New York City was created by the Center for Alternative Sentencing and Employment Services to provide a sentencing option for mentally ill prison-bound felony offenders. Program clients have committed serious offenses, including burglary, robbery, assault, and sexual assault. Once accepted into the program, a comprehensive treatment and supervision program is developed, generally including residential treatment, services for co-occurring substance abuse disorders, and intensive community integration support.

<u>Probation and Parole</u>

Services for mentally ill probationers can be most effective when they are provided through special programs staffed by officers with specialized training and experience. For probation services to be successful with the mentally ill, they must address the broad range of offenders' needs and work in collaboration with other agencies and services to ensure that these needs are met.

➢ Increase access to mental health professionals. According to the National Institute of Justice, 82% of probation and parole agency directors indicated the need for such access. One such effort, the Maryland Community Criminal Justice Treatment Program, is a multi-agency collaborative providing shelter and treatment services to mentally ill offenders on probation and parole, or in jail. Each local program has case managers on staff who link mentally ill offenders with screening and needs assessment services, counseling and discharge planning, and referral and monitoring in the community.

➢ Provide specialized cross-training to parole and probation officers about the characteristics of serious mental illnesses, the effects that these illnesses have on daily functioning, and the goals and desired outcomes of treatment. Include crisis intervention, screening, counseling, discharge planning and community follow-up in case management services.

➢ Understand the requirements of confidentiality statutes and mental health law. Identify mental health and other services available in the local area and learn how to access them, along with the government-funded benefits available to these individuals.

➢ Screen individuals for social, medical, clinical and criminal justice factors that would place the client at risk of failing his or her reintegration into the community. Include crisis intervention, screening, counseling, discharge planning, and community follow-up in case management services.

➢ Allow for continuous monitoring, increased communication between community supervision and other provider agencies, greater client responsibility, and more flexible sanctions that allow for some mistakes without an immediate return to jail or prison.

➢ Provide training for culturally competent community corrections.

➢ Help individuals with multiple problems (mental health, co-occurring substance abuse, poverty, housing, other social services) and focus on preventing persons with co-occurring disorders from relapsing into substance abuse. Encourage small caseloads and frequent interaction between case management staff and client.

➢ Fund transition services for parolees. Evaluate the effectiveness of specialized divisions or units with specific responsibility for coordinating and administering services for people with mental illnesses who are on probation.

Jail and Prison

Correctional facilities are poor settings for providing mental health care. The earliest possible diversion of individuals to the community or to residential treatment services is generally in the best interests of all concerned. Community based treatment and case management services are more likely than jail admissions to stabilize individuals and reduce recidivism. Offenders who may present a danger to the public should receive treatment in secure forensic facilities, not in settings that only worsen their condition.

Suicide Prevention

Suicide rates among mentally ill inmates who have made previous attempts are more than 100 times higher than the rate in the general population. Over 50% of jail suicides are committed within the first 24 hours in jail. More than 95% of those who commit suicide in correctional facilities have a treatable psychiatric illness. Suicide prevention in jail depends upon the ability of corrections and mental health staff to cooperate in identifying inmates at risk, and providing the treatment and monitoring necessary to ensure their safety.

Mental Health Services

Jail mental health professionals are needed to recognize and respond to inmates experiencing psychiatric symptoms and to ensure access to appropriate medication in the proper dosage. Services should include the following:

➢ Identify service providers for incarcerated mentally ill persons, including suicide assessment, screening, crisis intervention, classification and referral, prevention and intervention, in-jail counseling, discharge planning and community follow-up.

➢ Provide specialized services for subgroups of mentally ill inmates, such as those who are homeless and/or have co-occurring substance abuse disorders.

➢ Develop a discharge planning program for mentally ill inmates to be released from State prison to ensure that they are connected to appropriate community resources, including supervision, treatment and housing.

➢ Develop liaison with local Social Security offices to facilitate reinstatement of Federal disability benefits (SSI, SSDI, Medicaid) for mentally ill inmates when they are to be released from jail or prison.

CONCLUSION

The number of mentally ill persons confined in prisons and jails has increased dramatically over the past several decades. This has been the result in part of the expansive growth of these institutions generally, but has also been a function of factors relating to the care of mentally ill people in community settings. As deinstitutionalization became a guiding policy in regard to mental hospitals the failure to simultaneously support community-based mental health services led almost inevitably to a host of problems which ultimately came under the jurisdiction of the criminal justice system.

This set of factors has resulted in a situation which is unsatisfactory to all involved. Mentally ill persons often do not receive appropriate services, which may contribute to behaviors that bring them into contact with the criminal justice system Criminal justice practitioners are faced with limited resources with which to confront issues that would often be better suited to other institutions. And communities are not well served by the negative consequences of untreated mental illness.

As the programs and policies recommended in this report demonstrate there are often more constructive options available by which to respond to the challenges posed by mental illness. Foremost among these is the need to provide more intensive services in communities in order to aid mentally ill individuals to lead functional lives and to reduce the incidence of criminal behavior. Within the criminal justice system policymakers and practitioners can develop new means of working collaboratively with other community institutions to assess, diagnose, and respond appropriately to criminal involvement by mentally ill offenders. Such a framework would help communities develop systemic responses that both promote public safety and reduce the inappropriate confinement of individuals with mental illness.