Influences on the Burden of Serious Mental Illness in the U.S. Correctional System

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Jails in America have become warehouses for those with serious mental illness. Many with psychotic or substance abuse disorders cycle between jail and inadequate living arrangements, with high rates of recidivism and limited programs to address their illnesses. Although designed for detention rather than treatment, many jails in the United States have become de facto psychiatric hospitals (Forensic Taskforce of the NAMI Board of Directors, 2008).

As of June 2008, the total population of jails and prisons was 2,310,984 (U. S. Department of Justice, 2009). Of these, 785,556 inmates were housed in local jails (Minton & Sabol, 2009), an increase of 26% from 2000. A recent study systematically assessed the occurrence of mental illness in jail populations (Steadman, Osher, Robbins, Case, & Samuels, 2009). Using a structured clinical interview to determine psychiatric diagnosis, the investigators demonstrated a prevalence of serious mental illness[1] in 16.9% of inmates. This yields an estimate of approximately 133,000 affected individuals in jails nationwide.

Rates of serious mental illness, substance use disorders and history of homelessness are high among jail detainees, and these factors are associated with longer duration of incarceration (McNiel, Binder, & Robinson, 2005). Mental illness also confers an increased risk for recidivism following release from jail (Baillargeon, Binswanger, Penn, Williams, & Murray, 2009). Many with serious mental illness cycle between jail, urgent hospitalization for exacerbation of psychiatric illness, and homelessness (Hoge, 2007). There is a bidirectional relationship between risks of incarceration and homelessness, with mental illness, substance abuse and socioeconomic disadvantage as contributing factors (Greenberg & Rosenheck, 2008).

A parent's account published earlier this year in *Psychiatric Services* (Genengels, 2009) is illustrative of the problems that individuals with mental illness and their families encounter when

dealing with the criminal justice system. The article recounts the story of a mother whose adult son, John, was delusional and suicidal. The local county-designated mental health professional (CDMHP) whom she called for assistance contacted police to take John to the hospital.

> Several squad cars surrounded John's apartment, attracting the attention of his neighbors. The police entered John's home and tried to cuff him. Alarmed and bewildered by the situation, John cried, "What did I do? What did I do?" as he fled to his bedroom. The police officer followed in hot pursuit. He then ordered [John's father] and the CDMHP to go outside. There was a scuffle before another officer used his stun gun on our son's heart and stomach and dragged him off in front of his neighbors. (Genengels, 2009, p. 726)

Despite not having assaulted or injured the officers, John was charged several months later with third degree felony assault. He spent several months alternating between jail, inpatient treatment and competency training, and became suicidal awaiting trial. To avoid escalation of his charges to second degree assault with the possibility of a ten year prison sentence, on the advice of his attorney he agreed to a plea bargain with a guilty verdict and credit for time served. Because he now had a felony record, John has faced difficulties obtaining employment and housing.

The story is not an uncommon one. This first-person account is taken from one of over 2,500 letters that researchers received in response to a single item placed in a "Dear Abby" column to solicit stories from individuals and families about mental illness and the criminal justice system (Committee on Psychiatry and the Community, 2009).

In many cases, less severe offenses committed by those with mental illness – that could easily be managed without engagement in the criminal justice system – result in criminal conviction or incarceration. Some with mental illness are arrested because they have committed violent crime, but it is more often a circumstance of minor offenses committed as a result of the

illness, psychiatric symptoms that are mistaken for unlawful behavior, or "mercy arrests" of the mentally ill to remove them from the streets (Butterfield, 1998).

As the Committee on Psychiatry and the Community and the Group for the Advancement of Psychiatry (2009) have stated, "the system is organized for failure, with jail as the ultimate safety net."

This paper examines the development of policy in mental health and criminal justice for adults with serious mental illness who have involvement with the correctional system, and how these may contribute to a continuing, substantial burden of mental illness in jails and prisons. In particular, the following areas are discussed:

- economic impact of correctional system involvement of adults with serious mental illness,
- historical developments in mental health and criminal justice policies and their potential influence on the correctional system burden of mental illness,
- attitudes about mental illness and criminal behavior that may influence mental health care, criminal justice disposition or policy for this population, and
- recommendations on criminal justice and treatment approaches.

Economic Impact of Correctional System Involvement of Adults with Serious Mental Illness

The economic burden of mental illness is substantial. Considering only a portion of the costs of serious mental illness in the U.S. yields an estimate of $312 billion annually (Insel, 2008). This figure includes direct costs for mental health care, disability income benefits, public housing and food stamps, and loss of income (for those in households) due to mental illness. What it does not include are the costs attributable to medical comorbidities and complications,

estimates of productivity loss for those who are homeless or are in psychiatric institutions or correctional settings, costs of prosecution or imprisonment of the mentally ill, and other indirect costs.

A report by the American Psychiatric Association (2004) provides a clear summary of the issues:

> Under existing conditions, if a person with a mental illness commits a crime, a cost-ineffective cycle is set in motion. First the person with mental illness is charged with a crime and resources are expended to prosecute the case and imprison the offender. In prison, in addition to the regular costs associated with the housing of inmates, resources are expended to treat the condition…. Treatment received in jails and prisons for mental illness is usually directed toward suppressing symptoms rather than toward managing the illness, so the illness is, in effect, undertreated. A person with mental illness who is treated in jail or prison tends to leave incarceration with a treatment experience that in no way reduces the chance for recidivism and which may, in fact, increase the chance of returning to confinement. All suboptimal treatment experiences adversely affect subsequent treatment compliance, and this adverse effect carries increased costs not only for the criminal justice system, but also for public mental health services. Opportunities for cost effectiveness are lost when resources are used to address erupting crises rather than for ongoing illness management….Upon release, these offenders generally encounter an underfunded, inadequate, or nonexistent support network, which increases the likelihood that there will be a recurrence of the illness that manifested itself in the kind of behaviors that created the previous encounter with the criminal justice system. The former prisoner is picked up for loitering or disturbing the peace and the resource-draining cycle begins anew (p. 5).

The net effect of current policies as reflected in the cycle described above is a shift in financial responsibility for the care of a large number of individuals with serious mental illness from the mental health care system to the criminal justice system. However, estimating overall costs for the mentally ill involved with the correctional system may have particular complexities. Direct and indirect costs may accrue to the budgets of multiple governmental and private agencies. From a community (or taxpayer) perspective, costs related to the criminal justice system may include those related to the courts, prosecution and legal defense, law enforcement or correctional expenditures; those related to the health care system include inpatient and outpatient care, residential treatment, and costs of emergency care (Cowell, Broner, & Dupont, 2004). A recent study estimated mental health care, social service and criminal justice expenditures over one year for individuals with serious mental illness who had been incarcerated in a single Florida county jail [2] to be $23.4 million (Teague, 2009).

Linkage of individual-level information from separate health care, social service and criminal justice data sets permits a more comprehensive estimate of total societal costs, as well as analysis of the relationships between demographic, clinical, criminal justice and economic variables. For the Florida county cohort in the study cited above, the investigators were able to identify that a group characterized by the highest number of arrests (16 per year) over a four-year period were more likely to have a substance abuse diagnosis, to have been homeless at some time during the study, and to have had more inpatient or emergency room visits and fewer outpatient visits (Constantine, Petrila, & Andel, 2009). In addition, there was a suggestion that lower investments in health during the first two years of the study period were associated with higher criminal justice expenditures during years three and four (Robst, 2009).

These data begin to quantify the costs to a community of criminal justice involvement of those with serious mental illness. Additional studies can assist policy makers and the public at large to understand the considerable economic impact as well as the effectiveness of interventions to improve care and criminal justice disposition (Council of State Governments, 2002).

Development and Impact of Mental Health and Criminal Justice Policies

Parallel developments in mental health, social welfare and criminal justice policy have influenced the disposition and care of the mentally ill who are involved with the correctional system. Disparate stakeholders in federal, state and local government and in the private sector have worked primarily to serve the interests of their own constituencies, with resulting policy decisions having unintended effects on other components of a fragmented and costly system of care.

Since the early 19th century, cycles of reform have shifted the boundaries of public responsibility for care of the mentally ill between the mental health, social welfare and criminal justice systems (Morrissey & Goldman, 1986). In the early 19th century, the mentally ill were cared for in homes, in smaller asylums that advocated for cure by "moral treatment", or in local almshouses. The latter part of the 19th century saw a large-scale movement to state asylums, by then termed "mental hospitals." Growth in state institutional populations continued through the 1950s, until the deinstitutionalization movement of the late 1950s and 1960s (Grob, 1992). Throughout this time, and perhaps continuing to the present day, changes in policy and the relative responsibilities of various interest groups for care of the dependent, mentally ill resulted in shifts from one institutional setting to another, which has been termed *transinstitutionalization* (Morrissey & Goldman, 1986). Through the past two centuries, the mentally ill have moved

between care within families, private mental hospitals, community care in almshouses and jails, and large state institutions, with the present-day system a complex patchwork of private and public, centralized and decentralized settings for treatment or custodial care.

More recently, psychiatric inpatient care for many persons with serious mental illness has been provided in jails and prisons (Lamb & Weinberger, 2005). A significant driver in the growth of correctional system provision of care for the mentally ill may be the policies implemented beginning in the 1950s and 1960s that led to massive reductions of inpatient, psychiatric hospital capacity. In addition, unrelated changes in the criminal justice system over the past thirty years, and the reaction of law enforcement to increasing engagement with individuals affected by serious mental illness, may also be important factors (American Psychiatric Association, 2004).

Shift from Hospital- to Community-based Care

Historical approaches to institutional care from the mid-nineteenth to mid-twentieth centuries. The second half of the twentieth century saw a dramatic decline in the population of state mental hospitals. In 1955, the total state mental hospital census was over 500,000 (Morrissey & Goldman, 1986). By 2000, this had declined to 55,000 (Manderscheid et al., 2002 as cited in Hoge, 2007). This was the result of changes in policy affecting care of the mentally ill that had developed over many years; the antecedents of deinstitutionalization are embedded in the changing societal approaches to mental illness dating from the nineteenth century.

By the mid-1940's, the primacy of the mental hospital as the locus of treatment for the mentally ill was fading, and its legitimacy under challenge (Grob, 1992). Unlike the institutions of the late nineteenth and early twentieth centuries, the psychiatric hospitals of the 1940s had large proportions of chronic patients. In the 1850s, hospitalizations for the mentally ill were

shorter, with durations of three to nine months, and there was a perception that this confinement had therapeutic benefit (Grob, 1994). The length of hospitalization increased considerably over the first half of the twentieth century: The proportion of patients hospitalized for 12 months or less dropped from 27.8% in 1904 to 17.4% in 1924; hospitalizations of five years or longer increased from 39.2% to 54.0% (Grob, 1994).

Through much of the nineteenth century, individuals considered as chronically insane were held in local almshouses or maintained in the community, with most states requiring that local governments bear financial responsibility (Grob, 1992). Competition and pressure existed between state and local governments to pay for services for the mentally ill, financial responsibility was divided and there was a relatively low proportion of chronic patients in hospitals.

In parallel to other changes in health care that resulted from the shift to a more urbanized, industrial society in the early twentieth century, the states and larger institutions assumed a greater role in the care of the mentally ill. To address issues of quality of care in county- and municipality-administered asylums, the State Care Act was passed in New York in 1890 (Morrissey & Goldman, 1986). This legislation placed financial accountability for the institutional care of the mentally ill on the state, and relieved local governments of the obligation. Massachusetts, then other states, followed with similar legislation (Grob, 1992).

While the intent of these laws was improvement in quality of care, the effect was one of shifting large numbers of those with chronic mental disorders from community care to state asylums. This was the result of economic rather than humanitarian considerations, with local governments realizing an opportunity to transfer the financial burden for custodial care of many individuals to the state (Grob, 1992). Large numbers of the poor who were elderly and

demented, or suffering from other chronic mental afflictions, moved from locally-funded almshouses to state asylums. The population of state mental hospitals increased from 150,000 to 512,000 between 1903 and 1950, an increase of 240%, which was twice the change in the U.S. population during the same period (Morrissey & Goldman, 1986).

Growth of community mental health care. The Joint Commission on Mental Health, created in 1955 and co-sponsored by the American Medical Association and American Psychiatric Association, published its final report in 1961 (Grob, 1992). The report, entitled *Action on Mental Health,* recommended substantial increases in funding for mental health services (Smoyak, 2000). That year, President Kennedy formed the Interagency Task Force on Mental Health. This task force, along with the National Institute of Mental Health and others, advocated for community treatment of those with psychiatric disorders. The subsequent Community Mental Health Centers Act in 1963 provided funding to build such facilities. Construction and expansion of community centers occurred as a result of this legislation, and also under funding from the Hill-Burton program that contributed to expansion of general hospitals following World War II (Smoyak, 2000).

However, the mental health services for those with severe illness envisioned by the Community Mental Health Centers Act were never fully realized. Even though there was considerable growth in the provision of outpatient care, state hospitals continued to fulfill a major role in the care of those with chronic and intractable mental illness through the late 1960s and the 1970s. While outpatient treatment did grow dramatically, treatment in public psychiatric hospitals fell only modestly. The growth of outpatient services did not draw from the state hospital population, rather from new client populations with less severe conditions (Grob, 1992).

The momentum on mental health that had developed under President Kennedy was lost during the Johnson and Nixon administration due to escalation of the Vietnam War and other priorities that distracted from efforts to construct and staff community mental health centers. The Nixon administration was not supportive of community mental health programs, and the election of Jimmy Carter in 1976 was greeted with optimism by the mental health community (Grob, 1994). That year he created the President's Commission on Mental Health, which recommended expansion of community mental health efforts, and in 1980 the Mental Health Systems Act was passed. However, the election of Ronald Reagan later that year and the fiscal changes of the Omnibus Budget Reduction Act of 1981 reversed most of its provisions. At the time President Reagan came into office, only 754 of the intended 2,000 centers were operational (Smoyak, 2000). The severely affected patients that the community mental health centers were envisioned to have served remained without significant options for treatment, a situation that persisted under the budgetary policies of the 1980s.

Deinstitutionalization. In the 1940s and 1950s, introduction of more effective pharmacological treatments,[3] the growth of outpatient psychiatry and the exposure of abuse and substandard treatment at state hospitals were major factors influencing the move to deinstitutionalization (National Leadership Forum for Behavioral Health/Criminal Justice Services, 2009).

Deinstitutionalization, with its exodus of patients from state mental hospitals, occurred in two phases (Morrissey & Goldman, 1986). Between 1955 and 1965, the total reduction in hospital census was 15%, an average rate of 1.5% per year. During this time, census reductions were accomplished gradually by discharging patients with long stays and early discharge of recently-admitted patients. There was easy flux of patients in and out of the state hospitals

during this time, and they continued to act as a buffer when patients were not able to be managed in community settings. Because of this, the impact of deinstitutionalization on communities was not apparent, and the political backlash that would surface later had not materialized.

In the second phase, beginning around 1965, hospital census reductions were accomplished much more rapidly. Between 1965 and 1980, hospitals populations declined by 71%, with an average reduction between 1969 and 1976 of 10% per year. Admissions and length of stay were reduced drastically; inpatient treatment was brief and focused on stabilization of patients in crisis.

Once again, economic factors were a major driver for the shift of patients from one setting to another, in this case involving the rapid decrease in state mental hospital populations. The passage of amendments to the Social Security Act that created Medicare in 1965 encouraged the movement of large numbers of older patients from state hospitals to nursing homes, and the growth of third party plans facilitated the growth of psychiatric care in general hospitals (Grob, 1994). The economic crises of the 1970s put great budgetary pressure on the states, and contributed to the acceleration of state hospital census reductions. Medicaid provisions that permitted reimbursement for outpatient but not inpatient care for adults 21-64 years old, who comprised the greatest proportion of state hospital populations, promoted discharge of huge numbers of patients (Morrissey & Goldman, 1986). The Social Security Act of 1972, which expanded Social Security Disability Insurance and implemented Supplemental Security Income, further hastened the move from state hospitals to other settings in the community (Grob, 1994). In many instances, movement of patients from state hospitals to boarding homes and nursing homes substituted one custodial setting for another, and shifted financial responsibility between government budgets – in this case, from the state to the federal (Morrissey & Goldman, 1986).

In addition, the evidence of deinstitutionalization had started to become visible to the public, with streets in many communities populated by the homeless, many of whom had obvious mental illness and were often dirty, disheveled and at times exhibiting bizarre or threatening behavior (Talbott, 2004).

Another key consideration regarding criminal justice involvement of the mentally ill is the restrictiveness of criteria for civil commitment, which was a major factor in the rapid reduction in state mental hospital populations that occurred in the early 1970s (Morrissey & Goldman, 1986). In 1969, California enacted its revised civil commitment law, the Lanterman-Petris-Short Act, which was followed within 10 years by similar legislation in every state and Puerto Rico (Lamb & Weinberger, 1998). Such rapid adoption of legislation across states has few precedents. These laws required that commitment be based on dangerousness or inability to care for oneself rather than general concepts of mental illness and need for treatment. The laws also changed the provisions on length of commitment, with prohibitions against indefinite confinement and a requirement for commitment to be of limited and defined duration. The legislations also incorporated due-process provisions for rapid access to courts and legal counsel. The effect of these laws was fewer and shorter psychiatric hospitalizations, with only the most dangerous or incapacitated individuals being admitted to inpatient facilities (Lamb & Weinberger, 1998). However, the unintended result of these commitment laws was a substantial increase in the number of mentally ill persons who were homeless or incarcerated.

While the number of patients in psychiatric hospitals declined at the same time as the mentally ill in prisons and jails increased, the causal association of deinstitutionalization and incarceration is difficult to establish (Lamb & Weinberger, 1998). There are no data on the estimates of the mentally ill in correctional settings prior to deinstitutionalization, which prevents

comparison with illness burden from earlier eras. The concept of transinstitutionalization has been challenged, and data contradicting the concept of massive shifts of the mentally ill from hospitals to jails has been explained in part by the potential contribution of community support and psychotropic medication (Banks, Stone, Pandiani, Cox, & Morschauser, 2000).

Nonetheless, as Lamb and Weinberger (1998) note in a comprehensive review, there is substantial, supportive evidence for a shift from clinical to correctional settings of those with severe mental disorders, who are clinically indistinguishable from the state hospital patients of the past, and who now inhabit jails and prisons nationwide. There is little dispute for this conclusion among psychiatrists, advocacy groups, policymakers or those in the judicial and correctional systems.

Criminal Justice and Law Enforcement Policies

Incarceration of the mentally ill. The overall rate of incarceration of adults in the U.S. has risen dramatically. In the decades before 1970, the rate was fairly stable at 1 incarcerated person for every 1,000 adults in the population. During the 1970s, the rate rose to 5 per 1,000 (Hoge, 2007). As of 2008, that rate had more than doubled, with 1 in 99 adults in jail or prison, a total of over 2.3 million (Pew Center on the States, 2008). The number and percentage of citizens incarcerated in the U.S. is higher than any other nation. The growth in correctional populations varies widely from state to state, and the specific reasons in each state may differ. Many causes for this growth have been proposed, including mandatory sentencing guidelines, harsher sentences for drug-related offenses, and increasingly restrictive parole policies (Council of State Governments, 2002).

Each year in the U.S., more than 1.1 million individuals with mental illness are arrested and booked on criminal charges (National Leadership Forum for Behavioral Health/Criminal Justice

Services, 2009). While there has been societal endorsement of stricter law enforcement and sentencing, broad support for mental health services has been limited. Resultant inadequacies in community psychiatric treatment further increase the likelihood of engagement of the mentally ill with the criminal justice system (Lamb & Weinberger, 2005).

An important judicial system consideration related to mental illness is the approach of the courts to drug-related offenses. In 1988, President Reagan signed into law the Anti-Drug Abuse Act, which included among its provisions the imposition of mandatory sentences for drug possession. This may have had a disproportionate effect on the mentally ill (Hoge, 2007). Approximately 70% of new state prison admissions are due to nonviolent offenses, one-third of which are drug-related (Forensic Taskforce of the NAMI Board of Directors, 2008). It is known that individuals with substance abuse disorders have high rates of comorbidity with other psychiatric conditions (Kessler et al., 1994 cited in Lurigio & Swartz, 2000). A study in jail detainees undergoing drug treatment found a rate of undetected psychiatric comorbidity in 55%, with 19% meeting criteria for severe disorders (Swartz & Lurigio, 1999). Based on these data, it is likely that the implementation of stricter drug policies has had the consequence of increasing the correctional system burden of mental illness.

The role of law enforcement. The police play a significant role, and spend considerable time, dealing with the consequences of mental illness in the community. Teplin and Pruett (1992) have described the police gatekeeper role for the mentally ill as being that of a "streetcorner psychiatrist." While police jurisdiction and involvement with the mentally ill are mandated by law, the decisions governing disposition are extremely complex. Behavior can be informed by many aspects of the social context, and police may not have the technical training to

determine the contribution of psychiatric illness to behavior that appears disruptive or threatening.

Even when the police know that an individual has a psychiatric condition, their ability to direct them to mental health treatment is severely constrained (Lurigio & Swartz, 2000). Not only are the legal criteria for involuntary commitment strict, there may also be complex administrative procedures, resistance from health care providers to accept patients acting aggressively, and limited availability or long waiting periods for emergency room or inpatient beds. As a result, a law enforcement officer may prefer or be forced to arrest someone, even if they know the behavior to be the result of mental illness (Lamb, Weinberger, & DeCuir, 2002). According to Teplin and Pruett (1992), police use an "informal operative code" to determine how to handle an encounter with a mentally ill individual:

> Whether the disordered individual is defined by police to be "bad" (and should be arrested), "mad" (and therefore hospitalized), or merely "eccentric" is decided by discretion rather than by rules of law…. The police officers' decision to hospitalize, arrest, or manage a mentally ill citizen informally is based less on the degree of psychiatric symptomatology than on the sociopsychological and structural factors pertinent to each situation (p. 154).

The interactions of psychiatric illness with judicial and correctional approaches are complex. The term *criminalization* has been used to describe the arrest and prosecution of those with mental illness who have committed minor offenses, or are having psychiatric symptoms for which the police see arrest as the most expedient or viable option for an individual's protection or treatment (Lamb & Weinberger, 1998). However, this may result in someone with mental illness being labeled as an offender, which can have consequences for them both in their interactions with the judicial system as well as in the outside community. In subsequent

encounters, courts may place more weight on a past history of conviction than on whether the individual has a history of psychiatric disorder, which increases the likelihood of subsequent conviction or the severity of sentencing.

Incarceration may also result in disruption of treatment. Discontinuities in treatment, the psychological impact of imprisonment, or inadequate or inappropriate response of correctional staff can have a negative effect on psychiatric illness (American Psychiatric Association, 2004). Even when there is psychiatric evaluation and treatment available in a correctional facility and care is well-managed, the effects of a conviction can create additional burden for the individual. In some states, he or she must go through a Medicaid reapplication process following release, and experience delay in benefits and the potential for additional disruption in care. Social Security or Medicare payments may be affected as well. The criminalization of mental illness may also reinforce already negative public perceptions, and create additional stigma that could discourage others from obtaining needed treatment.

For serious crime, incarceration may be the most appropriate, necessary and likely outcome (Council of State Governments, 2002). It is the circumstance of the mentally ill who have committed minor offenses, for which the police elect arrest as the most viable option to obtain predictable psychiatric care or as the only feasible alternative to deal with a behavioral disturbance, that contribute to defining a symptom of illness as a criminal act and therefore to the correctional system burden of psychiatric illness.

Attitudes about Mental Illness and Criminal Behavior

The attitudes of care providers, those in criminal justice and the public at large have influenced policy on treatment of the mentally ill and their interactions with law enforcement and the courts. These attitudes underlie the trends in care of the mentally ill, the policies that have

led to the shifts in institutional settings of psychiatric care, and the approach of the criminal justice system these individuals.

Attitudes and Trends Related to Psychiatric Treatment

Morrissey and Goldman (1986) have reviewed historical developments in the treatment of mental illness during the past two centuries. They characterize the community mental health movement of the 1950s and 1960s as the third of three major cycles of reform dating from the early nineteenth century. According to the authors, each of these cycles "served to redefine the boundaries of the social welfare, mental health and criminal justice systems and to shift responsibility for dependent populations from one institutional setting to another" (p. 14).

The first reform cycle of the early 19th century, the Moral Treatment movement, resulted from the belief that the environment could be curative of insanity, and led to the creation of small asylums wherein a supportive, compassionate environment was fostered. They were characterized in their early years by some therapeutic successes, for the most part with groups of people who were homogeneous in their religious and cultural experiences. State-run asylums later adopted their practices, however increasing industrialization, the influx of large numbers of immigrants and growth in the numbers of the poor overwhelmed them and they were transformed over time into large, custodial care institutions. The more well-to-do with lesser degrees of mental affliction sought out smaller, private facilities, and the state institutions became the repository for the underprivileged with chronic mental illness.

The work of psychiatrist Adolf Meyer and the publication of *A Mind That Found Itself*, Clifford Beers' recounting of his experiences as a psychiatric patient, were pivotal to the second major reform cycle, the Mental Hygiene movement. This movement promoted the treatability of mental illness and advocated for early therapeutic intervention (Deutsch, 1944 as cited in

Morrissey & Goldman, 1986). One of the outgrowths of the Mental Hygiene movement was the establishment of "psychopathic hospitals" that were associated with major universities. However, as in the past, many who required prolonged care were admitted not to the university-affiliated institutions but to state hospitals, which largely maintained their custodial function for the poor and disabled (Morrissey & Goldman, 1986).

In the years following World War II, psychiatry moved dramatically to an emphasis on outpatient treatment, based in large part on the experiences of psychiatrists during wartime, who had been using brief interventions to treat the psychiatric sequellae of combat (Hoge, 2007). This represented the third major reform cycle, the Community Mental Health movement. Along with concurrent civilian experience of psychiatrists in treating victims of traumatic events, the success of brief interventions followed by rapid return to the pre-treatment setting provided an impetus for the development of mental health centers based in the community (Dixon & Goldman, 2004). In addition, psychoanalytic and other psychodynamic therapies came to dominate the field, which emphasized the effects of experience and environmental factors in mental illness (Grob, 1992). The result of these influences on psychiatric practice was a massive shift from hospital-based to community and office practice. By the mid-1950s over 80% of the members of the American Psychiatric Association were employed in outpatient settings. The ties of psychiatrists to hospital practice were weakened, as were their connections to treatment of those with the most severe forms of mental illness. The psychiatry community began to see the hospital as a relic, and essentially abandoned it as a primary locus of care (Grob, 1992).

As Morrissey and Goldman point out (1986), there are commonalities in each of the cycles of reform, including the Community Mental Health movement: Each promised a new treatment

setting with benefits to the patient and society; there was limited awareness of the practical limits of each movement; they proved applicable only to patients on the milder end of the illness spectrum; and they were ultimately derailed by unanticipated changes in surrounding circumstances.

The potential influence of growing movements against psychiatry in the 1950s and 1960s also warrants consideration. Arising in the developing schism between psychodynamic and biological psychiatry, what was later described as the *antispsychiatry movement* had its origins among intellectuals in the U.S. and Europe, its growth fueled by the attitudes of social rebellion in the 1960s (Rissmiller & Rissmiller, 2006). Involuntary hospitalization and the use of potent medications, electroconvulsive therapy and now-discredited surgical treatments were seen as coercive and, in the extreme, as criminal violations of individual autonomy. The American psychiatrist, Thomas Szacz, denounced the diagnosis of schizophrenia as a fictional construct, and the practice of psychiatry as colluding with government authorities in the suppression of individual freedom (Rissmiller & Rissmiller, 2006).

Notions of autonomy were also reflected in the courts, and the deinstitutionalization movement has as one of its legal tenets the "right to treatment in the least restrictive environment," established in 1967 in the United States Court of Appeals for the District of Columbia by *Lake v. Cameron* (Marty & Chapin, 2000). In this case, a plaintiff challenged her involuntary commitment, and the court held that the institution was required to explore other alternatives prior to hospitalization. In addition, other cases challenged state institutionalization as violating the legal tenet of freedom from harm, and the potential of poorly staffed or maintained hospitals to subject patients to "cruel and unusual punishment" (Marty & Chapin, 2000). Stakeholders from the legal and medical communities may align on many issues in the

treatment of the mentally ill, however this agreement may often "dissolve" in the face of addressing needs of individuals who do not voluntarily engage in treatment (Council of State Governments, 2002). Arguments about involuntary commitment encompass crucial ideas about individual autonomy in conflict with the need for treatment of severe illness, which may have as cardinal features an impairment of insight and inability to care for one's own needs.

Societal Attitudes toward Mental Illness and Its Relationship to Criminal Behavior

To understand what can occur during the arrest and conviction of someone with serious mental illness, it is important to know how mental illness can influence violence and criminal behavior. Well-publicized stories of mentally ill individuals committing acts of violence contribute to widespread stigma about the mentally ill and to notions about their dangerousness and need for incarceration. A deeper understanding about mental illness, and what characteristics or diagnoses are important to the causation of violence, are crucial to an informed approach.

It is established that individuals with serious mental illness have a higher incidence of violent behavior than the general population (Lamb & Weinberger, 1998). However, the manifestations of violent behavior depend on the type of mental illness, and the specifics of the psychiatric condition should be considered. In one study, the lifetime prevalence of violent behavior for those with schizophrenia, bipolar disorder or major depression was shown to be 16.1%, compared to 7.3% for those with no major disorder (Swanson, 1994 as cited in Friedman, 2006). This study showed that certain subgroups of patients with serious mental illness are at higher risk for violent behavior, including those with a history of substance abuse or dependence, as well as prior history of violent behavior and non-adherence to medication (Torrey, 1994). However, substance abuse alone has been shown to confer a greater risk for violent behavior

than the presence of schizophrenia, bipolar disorder or major depression (Swanson, 1994 as cited in Friedman, 2006). The vast majority of those with serious mental illness are not violent. In fact, those with serious mental illness are much more likely to be the victim than the perpetrator of violent acts (Choe, Teplin, & Abram, 2008).

The attitude of the public toward crime and prosecution has favored increasingly punitive approaches, as manifested by the growth in incarceration rates in the U.S. Special considerations or lenience for the mentally ill may have limited acceptance by the general public and the criminal justice system (Lamb & Weinberger, 1998). The approach to a given social problem is driven by public attitudes and views of morality (Kingdon, 1984 as cited in Mechanic & Tanner, 2007). A benevolent societal view, and the receipt of government assistance, is more likely if a given vulnerable population is viewed as not having personal responsibility for their life circumstance (Mechanic & Tanner, 2007). If a member of a given vulnerable population is seen as more "sinner" than "victim", public compassion is less likely.

The idea that mental illness is volitional or an attempt to evade prosecution, as well as societal fear of the potential of someone with a psychiatric disorder to commit violent crimes, may reinforce the tendency to favor punitive rather than therapeutic approaches (Lamb & Weinberger, 1998). In addition, the public and the courts may have a more favorable view when the individual is willing to acknowledge the illness and the need for treatment (Conrad & Schneider, 1980 as cited in Lamb & Weinberger, 1998). This may be particularly problematic for some psychiatric disorders, in which a lack of insight and awareness of the condition can be a fundamental feature of the illness (Rickelman, 2004).

Potential Solutions in Criminal Justice and Mental Health

A person with mental illness has multiple points of contact with the criminal justice system following a law enforcement encounter. Once arrested, a mentally ill individual may progress through trial, adjudication, sentencing, incarceration and ultimately release to the community and to the mental health system.

The Justice Center of the Council of State Governments (2002) has summarized components of the progression from the community to the criminal justice system, which provides a framework for considering potential interventions:

- Contact with law enforcement
- Pretrial issues, adjudication and sentencing
- Incarceration and reentry

This section focuses on select examples of solutions that have been implemented or recommended for law enforcement engagement, pretrial disposition and community reentry for those with serious mental illness.

Law enforcement interactions

Beginning with the response to an initial call, procedures can be implemented to ensure the appropriate disposition (Council of State Governments, 2002). Dispatchers can be provided with tools to determine whether mental illness may be a factor in a given call, if there is violence or the involvement of weapons, and who are the appropriate personnel or teams to respond.

A number of approaches have been developed for the police approach to the mentally ill. The goal of these programs is to maintain the safety of all parties involved in the encounter – the police, victim, bystanders, family members and the individual with mental illness – and ensure

an appropriate outcome that provides fair and dignified treatment (Council of State Governments, 2002).

The crisis intervention team model is one of the most widely utilized response programs. In this approach, a specialized group of police officers within a department are trained to manage calls involving an individual with mental illness (Compton, Bahora, Watson, & Oliva, 2008). They have instruction in managing the law enforcement encounter and in redirecting individuals to mental health services rather than the judicial system when appropriate. The crisis intervention team model was initially developed in Memphis, and has since been implemented in many communities nationwide. This model has been demonstrated to have positive outcomes including reduction in arrests and re-arrests, in shootings of individuals with mental illness and injuries to police officers, and increasing referrals for mental health treatment (Forensic Taskforce of the NAMI Board of Directors, 2008).

Other models include Comprehensive Advanced Response, in which all officers receive specialized response training; a system with concurrent response of police and civilian mental health professionals; and Mobile Crisis Teams, in which civilian mental health professionals act as secondary responders once the police have secured a scene (Council of State Governments, 2002). In each of the models described, the responders must accurately recognize the features of a mental illness, assess whether there has been a crime and if it was serious, engage mental health professionals or emergency services appropriately, and determine the needed actions resulting from the encounter.

Pretrial period, adjudication and sentencing

In communities where specialized law enforcement programs have been implemented, many individuals with mental illness can be diverted to treatment rather than to judicial

disposition (Council of State Governments, 2002). More commonly, diversion efforts occur after booking, either after an individual is in jail or while they are in adjudication court (Cowell et al., 2004). In such post-booking diversion programs, stakeholders in the criminal justice and mental health treatment systems collaborate to provide plans for treatment and, if needed, court oversight. In these programs, waiver of charges or reduction in terms of imprisonment is contingent on participation in mental health treatment (Rivas-Vazquez et al., 2009). The goal of the programs is to lessen the potential for subsequent criminal acts and reduce recidivism and engagement of an individual with mental illness in the criminal justice system (McNiel & Binder, 2007).

One of the most commonly implemented approaches to post-booking diversion is the mental health court, a specialized court that involves mental health and judicial system personnel in a non-adversarial, collaborative team that hears cases involving individuals with mental illness (Lamb & Weinberger, 2008). The mental health court cooperates with the mental health providers and social services in treatment, housing, vocational rehabilitation and other services (Forensic Taskforce of the NAMI Board of Directors, 2008). An underlying principle for these courts is one of therapeutic jurisprudence, which provides that the law should promote physical and mental well-being (Slate & Johnson, 2008).

Mental health courts have been criticized based on arguments that they are coercive and that they constitute a form of segregation based on psychiatric disability (Stefan & Winick, 2005). Critics argue that creation of a separate system to address the needs of these individuals, in response to a failure of the courts to deal fairly with those who are poor and mentally ill, is not a justifiable solution.

Incarceration and reentry

Release from prison typically occurs under one of three scenarios: statutory release to supervision, discretionary parole, or mandated release after completion of a sentence (Council of State Governments, 2002). Many states have eliminated discretionary parole, which has reduced the ability to tailor parole requirements to those with mental illness. Several states have implemented collaborations with mental health care providers to assist parole boards in coordinating issues regarding release of inmates with mental illness.

For jail inmates, issues may need to be addressed differently. Inmates may be released from jail with less predictability than prison inmates, so particular tactics may need to be applied to anticipate reentry. For example, the Cook County Jail in Chicago provides a daily census to area mental health clinics in order to aid with continuity of treatment when an inmate is ultimately released (Council of State Governments, 2002). Additional measures can be implemented through consent procedures and with family members to aid continuity of treatment. Given that many of the mentally ill who have committed minor offenses may be booked into jails rather than prisons, that duration of incarceration may be short, and that release may not be predictable or coordinated, the population of mentally ill cycling through jails present particular challenges (L. Rosenberg, personal communication, November, 2009). Forensic Assertive Community Treatment (FACT) programs have been established to address needs of the population of individuals with mental illness who cycle in and out of the criminal justice system (Forensic Taskforce of the NAMI Board of Directors, 2008). These programs utilize a multidisciplinary, mobile team to provide treatment and support in the community for individuals at high risk for relapse. Teams utilize a highly coordinated approach and intervene to

prevent hospitalization or incarceration, and can align with the criminal justice system to foster diversion into treatment programs and reduce recidivism (Lamberti, Weisman, & Faden, 2004).

Collaboration between mental health and judicial system stakeholders

Individuals with mental illness involved in the correctional system encounter components of both the mental health care and criminal justice communities. The burden and expense that is created accrues to diverse agencies and branches of government.

The education of policymakers and the public is critical to understanding how fragmentation and gaps in care can have devastating consequences (Bonnie, Reinhard, Hamilton, & McGarvey, 2009). It is often a galvanizing event that pushes system reform, and the violent tragedy at Virginia Tech in 2007 is an example of this. During a swell of public support and awareness following that event, laws in Virginia governing civil commitment were revised in the spring of 2008 as part of a comprehensive legislation aimed at system reform. What is not certain is whether there will be sustained support for needed transformation with limited government budgets and competing priorities (Bonnie et al., 2009).

A feature of the reform in Virginia is a drive for collaboration between the mental health and judicial communities. The most effective solutions will require collaboration between diverse stakeholders. Only with this collaboration can communities realize substantial benefits: reducing engagement of the mentally ill with the criminal justice system, improving safety for the public and for law enforcement, reducing costs and improving systems of care. As stated by the Consensus Project report from the Council of State Governments Justice Center (2002), “The failure of these systems to connect effectively endangers lives, wastes money, and threatens public safety—frustrating crime victims, consumers, family members, and communities in general” (p. 188).

References

American Psychiatric Association. (2004). *Mental illness and the criminal justice system: Redirecting resources toward treatment, not containment*. Arlington, VA.

Baillargeon, J., Binswanger, I. A., Penn, J. V., Williams, B. A., & Murray, O. J. (2009). Psychiatric disorders and repeat incarcerations: the revolving prison door. *American Journal of Psychiatry, 166*(1), 103-109.

Banks, S. M., Stone, J. L., Pandiani, J. A., Cox, J. F., & Morschauser, P. C. (2000). Utilization of local jails and general hospitals by state psychiatric center patients. *Journal of Behavioral Health Services & Research, 27*(4), 454-459.

Bonnie, R. J., Reinhard, J. S., Hamilton, P., & McGarvey, E. L. (2009). Mental health system transformation after the Virginia Tech tragedy. *Health Affairs, 28*(3), 793-804.

Butterfield, F. (1998, March 5). Asylums behind bars: a special report; prisons replace hospitals for the nation's mentally ill. *New York Times*, A1.

Choe, J. Y., Teplin, L. A., & Abram, K. M. (2008). Perpetration of violence, violent victimization, and severe mental illness: Balancing public health concerns. *Psychiatric Services, 59*(2), 153-164.

Committee on Psychiatry and the Community, Group for the Advancement of Psychiatry,. (2009). Jailing is failing people with mental illness. *Psychiatric Services, 60*(6), 723.

Compton, M. T., Bahora, M., Watson, A. C., & Oliva, J. R. (2008). A comprehensive review of extant research on Crisis Intervention Team (CIT) programs. *Journal of the American Academy of Psychiatry & the Law, 36*(1), 47-55.

Conrad, P., & Schneider, J. W. (1980). *Deviance and medicalization: From badness to sickness*. St. Louis: Mosby.

Constantine, R., Petrila, J., & Andel, R. (2009). *Arrest trajectories of adults with serious mental illnesses*. Paper presented at the 137th Annual Meeting of the American Public Health Association, Philadelphia, PA.

Council of State Governments. (2002). *Criminal justice / mental health consensus project*. Lexington, KY.

Cowell, A. J., Broner, N., & Dupont, R. (2004). The cost-effectiveness of criminal justice diversion programs for people with serious mental illness co-occurring with substance abuse. *Journal of Contemporary Criminal Justice, 20*(3), 292-315.

Deutsch, A. D. (1944). The history of mental hygiene. In J. K. Hall, G. Zilboorg & H. A. Bunker (Eds.), *One hundred years of American psychiatry*. New York: Columbia University Press.

Dixon, L., & Goldman, H. (2004). Forty years of progress in community mental health: the role of evidence-based practices. *Administration & Policy in Mental Health, 31*(5), 381-392.

Forensic Taskforce of the NAMI Board of Directors. (2008). *Decriminalizing mental illness: Background and recommendations*.

Friedman, R. A. (2006). Violence and Mental Illness -- How Strong is the Link? *New England Journal of Medicine, 355*(20), 2064-2066.

Genengels, C. (2009). A cry for help. *Psychiatric Services, 60*(6), 726-727.

Greenberg, G. A., & Rosenheck, R. A. (2008). Jail incarceration, homelessness, and mental health: a national study. *Psychiatric Services, 59*(2), 170-177.

Grob, G. N. (1992). Mental health policy in America: myths and realities. *Health Affairs, 11*(3), 7-22.

Grob, G. N. (1994). Mad, homeless, and unwanted: A history of the care of the chronic mentally ill in America. *Psychiatric Clinics of North America, 17*(3), 541-558.

Hoge, S. K. (2007). Providing transition and outpatient services to mentally ill released from correctional institutions. In R. Greifinger (Ed.), *Public Health Behind Bars: From Prisons to Communities* (pp. 461-477). Dobbs Ferry, NY: Springer.

Insel, T. R. M. D. (2008). Assessing the economic costs of serious mental illness. *American Journal of Psychiatry, 165*(6), 663-665.

Kessler, R. C., McGonagle, K. A., Zhao, S., Nelson, C. B., Hughes, M., Eshleman, S., et al. (1994). Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States: Results from the national comorbidity survey. *Arch Gen Psychiatry, 51*(1), 8-19.

Kingdon, J. W. (1984). *Agendas, alternatives and public policies*. Boston: Little, Brown.

Lamb, H. R., & Weinberger, L. E. (1998). Persons with severe mental illness in jails and prisons: a review. *Psychiatric Services, 49*(4), 483-492.

Lamb, H. R., & Weinberger, L. E. (2005). The shift of psychiatric inpatient care from hospitals to jails and prisons. *Journal of the American Academy of Psychiatry & the Law, 33*(4), 529-534.

Lamb, H. R., & Weinberger, L. E. (2008). Mental health courts as a way to provide treatment to violent persons with severe mental illness. *JAMA, 300*(6), 722-724.

Lamb, H. R., Weinberger, L. E., & DeCuir, W. J. (2002). The police and mental health. *Psychiatric Services, 53*(10), 1266-1271.

Lamberti, J. S., Weisman, R., & Faden, D. I. (2004). Forensic assertive community treatment: preventing incarceration of adults with severe mental illness. *Psychiatric Services, 55*(11), 1285-1293.

Lurigio, A. J., & Swartz, J. A. (2000). Changing the contours of the criminal justice system to meet the needs of persons with serious mental illness. In J. Horney (Ed.), *Policies, processes, and decisions of the criminal justice system*. National Institute of Justice, Office of Justice Programs, U.S. Department of Justice.

Manderscheid, R. W., Atay, J. E., Male, A., Blacklow, B., Forest, B., Ingram, L., et al. (2002). Highlights of organized mental health services in 2000 and major national and state trends. In R. W. Manderscheid & M. J. Henderson (Eds.), *Mental Health, United States, 2002*. Rockville, MD: U.S. Department of Health and Human Services.

Marty, D. A., & Chapin, R. (2000). The legislative tenets of client's right to treatment in the least restrictive environment and freedom from harm: implications for community providers. *Community Mental Health Journal, 36*(6), 545-556.

McNiel, D. E., & Binder, R. L. (2007). Effectiveness of a mental health court in reducing criminal recidivism and violence. *American Journal of Psychiatry, 164*(9), 1395-1403.

McNiel, D. E., Binder, R. L., & Robinson, J. C. (2005). Incarceration associated with homelessness, mental disorder, and co-occurring substance abuse. *Psychiatric Services, 56*(7), 840-846.

Mechanic, D., & Tanner, J. (2007). Vulnerable people, groups, and populations: societal view. *Health Affairs, 26*(5), 1220-1230.

Minton, T. D., & Sabol, W. J. (2009). *Jail inmates at midyear 2008: Statistical tables*. U.S. Department of Justice.

Morrissey, J. P., & Goldman, H. H. (1986). Care and treatment of the mentally ill in the United States: historical developments and reforms. *Annals of the American Academy of Political & Social Science*, 484, 12-27.

National Leadership Forum for Behavioral Health/Criminal Justice Services. (2009). *Ending an American tragedy: Addressing the needs of justice-involved people with mental illnesses and co-occurring disorders*.

Pew Center on the States. (2008). *One in 100: Behind bars in America 2008*. Washington, D.C.: The Pew Charitable Trusts.

Rickelman, B. L. (2004). Anosognosia in individuals with schizophrenia: toward recovery of insight. *Issues in Mental Health Nursing, 25*(3), 227-242.

Rissmiller, D. J., & Rissmiller, J. H. (2006). Evolution of the antipsychiatry movement into mental health consumerism. *Psychiatric Services, 57*(6), 863-866.

Rivas-Vazquez, R. A., Sarria, M., Rey, G., Rivas-Vazquez, A. A., Rodriguez, J., & Jardon, M. E. (2009). A relationship-based care model for jail diversion. *Psychiatric Services, 60*(6), 766-771.

Robst, J. (2009). *Patterns of criminal justice expenditures for adults with a serious mental illness involved in the criminal justice system*. Paper presented at the 137th Annual Meeting of the American Public Health Association, Philadelphia, PA.

Slate, R. N., & Johnson, W. W. (2008). *The criminalization of mental illness: Crisis and opportunity for the justice system*. Durham, NC: Carolina Academic Press.

Smoyak, S. A. (2000). The history, economics, and financing of mental health care. Part 2: The 20th century. *Journal of Psychosocial Nursing & Mental Health Services, 38*(10), 26-37.

Steadman, H. J., Osher, F. C., Robbins, P. C., Case, B., & Samuels, S. (2009). Prevalence of serious mental illness among jail inmates. *Psychiatric Services, 60*(6), 761-765.

Stefan, S., & Winick, B. J. (2005). A dialogue on mental health courts. *Psychology, Public Policy, and Law, 11*(4), 507-526.

Swanson, J. W. (1994). Mental disorder, substance abuse, and community violence: an epidemiological approach. In J. Monahan & H. J. Steadman (Eds.), *Violence and mental disorder: Developments in risk assessment* (pp. 101-136). Chicago: University of Chicago Press.

Swartz, J. A., & Lurigio, A. J. (1999). Psychiatric illness and comorbidity among adult male jail detainees in drug treatment. *Psychiatric Services, 50*(12), 1628-1630.

Talbott, J. A. (2004). Deinstitutionalization: Avoiding the disasters of the past. *Psychiatric Services, 55*(10), 1112-1115.

Teague, G. B. (2009). *Patterns of criminal justice expenditures for adults with a serious mental illness involved in the criminal justice system*. Paper presented at the 137th Annual Meeting of the American Public Health Association, Philadelphia, PA.

Teplin, L. A., & Pruett, N. S. (1992). Police as streetcorner psychiatrist: managing the mentally ill. *International Journal of Law & Psychiatry, 15*(2), 139-156.

Torrey, E. F. (1994). Violent behavior by individuals with serious mental illness. *Hospital & Community Psychiatry, 45*(7), 653-662.

U. S. Department of Justice, Bureau of Prison Statistics. (2009). Prison statistics. Retrieved November 16, 2009, from http://www.ojp.usdoj.gov/bjs/prisons.htm

Notes

1. Serious mental illness refers to more severe psychiatric disorders including schizophrenia or schizoaffective disorder, bipolar disorder, major depression, or one of several other disorders characterized by psychosis. In the cited study (Steadman et al., 2009), serious mental illness was defined as major depressive disorder; depressive disorder not otherwise specified; bipolar disorder I, II, and not otherwise specified; schizophrenia spectrum disorder; schizoaffective disorder; schizophreniform disorder; brief psychotic disorder; delusional disorder; and psychotic disorder not otherwise specified.
2. The study population was defined as any individual indentified from mental health service records as having a diagnosis of a serious mental illness, who had spent at least one day in jail during the year.
3. Thorazine® (chlorpromazine), the first of several new, effective antipsychotic medications, was introduced in 1954 (Hoge, 2007).