

Double Jeopardy

Persons with Mental Illnesses in
the Criminal Justice System

A Report to Congress

from the

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Executive Summary

On October 1, 1992, the Center for Mental Health Services (CMHS) was established as part of the ADAMHA Reorganization Act (42 U.S.C. 290bb-31). This law requires CMHS to produce a report to Congress concerning

“...the most effective methods for providing mental health services to individuals who come into contact with the criminal justice system, including those individuals incarcerated in correctional facilities (including local jails and detention facilities), and the obstacles to providing such services.”

Current Status

Persons with mental illnesses who come into the contact with the criminal justice system are particularly vulnerable. They bear a double burden: the stigma associated with their mental illness and the stress of potential arrest and confinement. Involvement with the criminal justice system may exacerbate the isolation and distrust often associated with mental illnesses.

At the same time, individuals with mental illnesses present special problems to the criminal justice system. Lack of knowledge about mental illnesses on the part of law enforcement and corrections staff, and a shortage of appropriate mental health services, may mean that these individuals are left untreated with symptoms that may worsen. Although it is in the best interest of all concerned to provide effective mental health treatment for persons in the criminal justice system, many obstacles stand in the way of providing appropriate care, including:

- lack of knowledge on the part of law enforcement and corrections personnel about effective mental health programs and how to access them;
- lack of understanding on the part of the mental health system about the demands and constraints of the criminal justice system and an unwillingness to work with clients with criminal charges or records;
- lack of cross-training among corrections, law enforcement, and mental health personnel; and
- lack of coordination among the criminal justice, mental health, and social service systems.

The Changing Context of Care

Inadequate or inappropriate information and fragmented services can result in persons with mental illnesses receiving no services at all or receiving inappropriate treatment, including arrest and jail, because working alternatives do not exist in the community. To address the unmet needs of persons with mental illnesses in the criminal justice system, the Center for Mental Health Services, a component of the Substance Abuse and Mental Health Services Administration, one of the eight Public Health Service agencies in the U.S. Department of Health and Human Services, was charged with the responsibility for preparing this report.

Dramatic changes in the mental health service delivery system in this country have occurred over the last 30 years. Prompted by the development of new medications, changing treatment philosophies, the activism of the civil rights movement, and significant new Federal funding for a nationwide network of community mental health centers, the number of patients in State hospitals declined from 560,000 in 1955 to 100,000 in 1989 (National Institute of Mental Health, 1991).

These changes caused the loss of State-operated inpatient beds and resulted in a blurring of fiscal and administrative responsibilities for the care of persons with severe mental illnesses, as well as a growing fragmentation in service provision as the number and breadth of service providers, both inpatient and outpatient, increased.

In 1992, the Federal Task Force on Homelessness and Severe Mental Illness reported that, in many communities, services to persons with mental illnesses are delivered by an often complex and disconnected set of bureaucracies that are difficult for individuals and their caregivers to negotiate. Housing is a particular problem for this population. In 1992, about 5 percent of the nearly 4 million persons with severe mental illnesses in the U.S. were estimated to be homeless at any given time.

At the same time, the criminal justice system has also undergone major changes. In 1993, the Bureau of Justice Statistics reported that in the last decade, the U.S. jail population on any day increased from 158,394 to 444,584. Similarly, the prison population increased from 329,000 to 824,133 in the same period. Fully 2.3 percent of the U.S. adult population is in jail, in prison, or on parole on any day, giving the U.S. the world's highest incarceration rate.

Burgeoning U.S. corrections populations are due to several policy changes, including the generally harsher sanctions resulting from the policy of "getting tough on crime" and the more recent "war on drugs." In addition, stiffer penalties have been imposed through sentencing reform legislation.

As jail and prison populations increased, and the number of persons with mental illnesses living at the fringe of their communities rose, the absolute numbers of persons with mental illnesses in jails and prisons also increased. Exacerbating the problem is a high degree of co-morbidity of severe mental illnesses and substance use disorders among jail and prison inmates.

In its 1992 report, *Criminalizing the Seriously Mentally Ill: The Abuse of Jails as Mental Hospitals*, the National Alliance for the Mentally Ill (NAMI) found that:

- 29 percent of jails that responded to a NAMI survey hold persons with severe mental illnesses without any criminal charges;
- 20 percent of jails that responded have no mental health services; and
- 46 percent of jails that responded do not know whether persons with mental illnesses released from jail receive outpatient mental health services upon release.

As the number of jail detainees and prison inmates continues to grow at an alarming rate, an enormous strain is placed on the resources of these institutions. There has never been a greater need for resources devoted to mental health care in these facilities.

A Heterogeneous Group

Persons with mental illnesses are a heterogeneous group. They are men and women of different ages, cultural and ethnic backgrounds, and sexual preferences. The effects of their mental illnesses range from psychosis, to severe disruptions in emotions, and functional impairment in their ability to relate to others or sustain work. All of these factors must be considered when developing mental health programs in the community and in the criminal justice system.

One prevalent myth about persons with mental illnesses is that they are prone to violence. The fact is that most persons with mental illnesses are no more likely than the general population to commit violent acts.

All persons with mental illnesses who come into contact with the criminal justice system have special needs. Yet special populations within this group, including people with co-occurring substance use disorders, women, ethnic and racial minorities, homeless persons, persons with HIV/AIDS, and youth, warrant particular attention.

Needed Services

Services for persons with mental illnesses who come into contact with the criminal justice system are critical and can be developed without substantial new funding. Much of what is required is rethinking how to address these problems. The development of specific services to persons who come into contact with police, who are incarcerated in jails or prisons, or who are supervised in the community by probation or parole departments, can be helped greatly by the adoption of core planning principles.

Many recent analyses of mental health services for underserved populations appropriately have emphasized the need for collaboration between private and public sectors and, in turn, among the local, State, and Federal levels of government. The core planning principles emphasize the need for comprehensive and integrated services at the client and system levels, with particular focus on the need for community collaboration.

The criminal justice system has differing responsibilities for individuals with mental illnesses at key contact points. Law enforcement officers must decide whether to arrest an individual who is in crisis or is creating a disturbance or to transport him or her to a mental health facility for treatment. Services that make this possible include 24-hour emergency mental health treatment facilities, mobile crisis teams that can assist in the resolution of the incident, transportation, and staff who can wait with an individual for an evaluation.

At lockups and jails, the safety of the detainee, other inmates, and custodial staff is the key issue. Half of all jail inmates leave within 24 hours. Key services at this point include identification of persons with mental illnesses through routine screening and follow-up evaluations, and stabilization of the individual through crisis intervention services. In addition, to facilitate the movement of persons with mental illnesses back into the community or to a prison setting, discharge planning and case management services are important.

Prisons are contained communities; inmates with mental illnesses have the right to treatment to improve the quality of their lives and to allow them to serve their time humanely. The optimum level of available services should duplicate the best that is available in the community, with a full range of inpatient and outpatient treatments and modalities available to all inmates.

Persons under community supervision (i.e., probation or parole) also need a full range of mental health services. These services should help maintain persons with mental illnesses in the community, keep symptomatology to a minimum, and reduce the risks of recidivism.

Diversion programs have been hailed as an important service for individuals with mental illnesses who do not belong in jail. Such individuals need to be diverted from jail, either before arrest or after booking, to a continuum of mental health and other community support services that includes outreach, case management, crisis intervention, housing, vocational training, and family support.

A Place to Begin The problems discussed in this report are complex and multifaceted. No single solution or program will address the needs of all persons with mental illnesses in the criminal justice system. However, the material compiled provides a place for Federal, State, and local officials, policymakers, mental health and corrections personnel, researchers, and advocates to begin talking about, and planning action to achieve, effective solutions.

Preface

Background

On October 1, 1992, the Center for Mental Health Services (CMHS) was established as part of the ADAMHA Reorganization Act (42 U.S.C. 290bb-31). This law requires CMHS to produce a report to Congress concerning “the most effective methods for providing mental health services to individuals who come into contact with the criminal justice system, including those individuals incarcerated in correctional facilities (including local jails and detention facilities), and the obstacles to providing such services.”

To define the objectives associated with this goal, an internal CMHS working group identified four primary areas of attention as suggested by the language of the Reorganization Act. They are:

- (Identifying the) ... ***most effective methods for providing mental health services***. Individuals with mental illnesses who come into contact with the criminal justice system may be diverted into the mental health system or treated within the criminal justice system. Information must be available on the range and type of mental health services needed by individuals both in the community and in the criminal justice system, the human and fiscal resources needed to support these services, and the anticipated outcomes of any intervention for the criminal justice system and for the individuals involved. Law enforcement agencies and local jails must be seen as an integral part of community-based care for this population.
- (Providing these services) ... ***to individuals who come into contact with the criminal justice system***. Persons with mental illnesses who come into contact with the criminal justice system are a heterogeneous group. To understand their needs, a complete discussion of this issue must focus on the specific characteristics of this population, including the degree of severity of mental illness, types of crimes committed, typical precipitating events, and the special needs of subgroups within the population, such as women, homeless persons, and persons with co-occurring substance use disorders.

- **...including those individuals incarcerated in correctional facilities (including local jails and detention facilities).** There are many points throughout the criminal justice system where persons with mental illnesses will be identified, including police contacts, locally operated lockups and jails, prisons, and community supervision (probation and parole). The responsibilities of the criminal justice system for persons with mental illnesses, and the needs of such individuals, will vary at each point throughout the system. These must be identified and clearly understood by providers in both the mental health and criminal justice systems.
- (and identifying) ... **the obstacles to providing such services.** Obstacles to providing appropriate care for persons with mental illnesses in the criminal justice system include human and fiscal constraints, organizational ownership (turf) issues, lack of knowledge on the part of the criminal justice system about effective mental health programs and how to implement them, and lack of understanding on the part of the mental health services system about the demands and constraints of the criminal justice system. These barriers must be identified and ways to overcome these barriers highlighted.

To insure that this report represents the range of issues and concerns of the many constituents involved, CMHS convened the Ad Hoc Working Group for Mental Health and Criminal Justice Systems consisting of consumers, family members, mental health providers to jails and prisons, law enforcement and corrections administrators, Federal and State criminal justice and mental health agency representatives, and a number of nationally known consultants (see the Appendix for a list of participants). The Ad Hoc Working Group met in July 1993 to discuss the major issues relating to the report and to recommend methods to implement model service programs. The group also reviewed drafts of this report and offered many suggested changes that are reflected herein.

The Scope of the Report

This report contains five chapters. Chapter One, "The Human Face of the Problem," presents an overview of the issues. Chapter Two, "The Changing Context of Care," provides a brief history of policy in this area, including discussions of the organization of mental health services in this country and changes in the criminal justice system that impact persons who have mental illnesses. The characteristics of persons with mental illnesses who come into contact with the criminal justice system, including several subgroups with special needs, are discussed in Chapter Three, "The Nature of the Population."

Chapter Four, "Defining the Needs of Persons with Mental Illnesses in the Criminal Justice System," discusses the needs of persons with mental illnesses at each stage of the criminal justice system, including police contacts, jails, prisons, and probation and parole, and outlines the responsibilities of, and challenges to, the criminal justice system at each contact point. Finally, coordinating essential mental health services for persons with mental illnesses in the criminal justice system, including examples of successful programs, are presented in Chapter Five, "Solutions That Work."

CHAPTER 1

The Human Face of the Problem

People Who Have Been There

Statistics alone can never adequately represent the concerns of persons with mental illnesses in the criminal justice system. Listen to the stories of those who have been there.

James

James had been in an Ohio city jail for six months. During that time, he was treated for depression and stabilized well. He had little family support in the community, and he was somewhat uncomfortable about his prospects when the time came for his release. Because of this, mental health staff within the jail made concrete release plans with him.

The staff made an appointment for him at the local mental health center that was within a few hours of his scheduled release time. He did not, however, receive a supply of, or a prescription for, the antidepressant medication he was treated with during incarceration.

James kept his appointment at the mental health center. However, he was told that he could not get medication for at least two weeks because the psychiatrist's schedule was full until then. When he asked about housing, he was told to come back the next day.

That night, James committed suicide.

Michael

The family of a young man from a rural county in upstate New York called the police to assist their son. Michael was acting strangely and refused to go to the hospital. When a State trooper responded to the call, Michael grabbed the officer's weapon and attempted to shoot him with it. The trooper subdued Michael and arrested him. He was charged with attempted murder and taken to jail.

The forensic mental health coordinator evaluated Michael upon entry into the facility. At the time, he was experiencing psychotic symptoms. He had a previous diagnosis of schizophrenia but had not been taking his prescribed medication. He had also been using some marijuana and was hearing voices telling him to kill.

Michael was transferred within 24 hours to an inpatient psychiatric hospital with which the county contracted for services. He spent three months there. When he was returned to the jail, the forensic coordinator had negotiated with the district attorney, Michael's public defender, and the county judge to reduce the sentence, in consideration of a plan for mental health treatment and community supervision.

Michael was sentenced to 6 months in jail and 5 years of probation, which required him to continue to receive mental health treatment. For good behavior and the time he spent in the forensic hospital, Michael served one month in the county jail.

While he was in jail, Michael continued to receive mental health treatment, and plans were made for his discharge. He was assigned an intensive case manager who met with him and coordinated his service needs before release. Close communication between community mental health staff and the probation officer guaranteed continuity of care for Michael and helped increase the likelihood that he would be able to function in the community.

Michael has required two brief hospitalizations in the last 5 years, but he has not had any further contact with the police. He recently moved out of his family's home into supported housing and is employed by a sheltered workshop.

Grace

Grace is a 60-year-old widow who lives alone in a suburban Pennsylvania town. For several years she has been calling the local police to tell them that people were breaking into her house and that someone was harassing her. Recently the police began to receive complaints from Grace's neighbors. The last time, Grace had apparently gone to a neighbor's house and threatened their children, even grabbing one and twisting his arm.

When the police were called for this incident, they felt they had to arrest Grace. Before doing this, however, they called a mobile mental health crisis team. The outreach workers who responded met with Grace, the police, and the neighbors. They also contacted Aging and Adult Services and located a relative.

The crisis team considered having Grace committed to an inpatient facility. She was psychotic, her home was filthy and in disarray, and she was very suspicious of the team. However, the mental health outreach team and Aging and Adult Services agreed to work with Grace.

Over the next few weeks, the outreach team visited Grace several times. She came to trust the workers and disclosed that she had been hospitalized in the past and that she had had a drinking problem. With the coordinated efforts of the mental health team and Aging and Adult Services providing her with support and home care assistance, Grace stabilized, and her home is in order again. There have been no calls to the police and no complaints from the neighbors.

Steven

Two years ago, a young male veteran arrived in Honolulu from California estranged from his family and broke. He had a diagnosis of paranoid schizophrenia. Within three months, he had amassed 11 arrests for minor misdemeanor charges.

Each time Steven was arrested, he was seen by the jail diversion program, which attempted to connect him to the Veterans Administration (VA) office. However, Steven proved to be very resistant to treatment. On his eleventh arrest, the jail diversion program director confronted Steven, telling him he might be facing lengthy jail time if this situation continued.

With Steven's permission, the program director contacted Steven's father, who admitted he was reluctant to have his son return home because he refused treatment and caused such disorder in the family's life. However, given his failures to function in Honolulu, the father agreed to work with the program director to develop a plan for Steven's return home.

The program director contacted the local VA program in Steven's hometown, which agreed to take his case and to be with the father at the airport when his son arrived. The prosecutor and the program director agreed that charges should be dropped, and the program director appeared in court on Steven's behalf to explain the situation. The judge dismissed all charges with prejudice, which means that the charges will remain dismissed as long as Steven does not return to Honolulu.

One of the stipulations the program director made was that he had to hear from Steven or his father at two month intervals until further notice. The father was reliable about checking in, and the notification period was extended to six months.

After Steven was back in California, the father called the program director to thank him. "Thank God for the diversion team," the father said. "Not only did my son come home, but he is in treatment right now. He is doing just fine." That was two years ago, and Steven is still doing well.

Two Complex Systems

The stories of James, Michael, Grace, and Steven are compelling evidence of the need for communication between the mental health and criminal justice systems and for collaboration to meet the needs of persons with mental illnesses. Such collaboration contributes to the smooth operation of the criminal justice system and promotes continuity of care for persons with mental illnesses. Michael, Grace, and Steven benefited from such collaborative efforts; James' suicide was a catalyst for increased communication and cooperation between jail and mental health staff.

To better understand the problems that exist at the intersection of these two complex service systems, Chapter Two looks at the changing organization of mental health services in this country and at the development of policy concerning the responsibilities of the criminal justice system with regard to persons who have mental illnesses.

CHAPTER 2

The Changing Context of Care

Background

The Governor of Virginia expressed dismay that he was “forced to authorize the confinement of [persons with mental illnesses] in the Williamsburg jail, against both his conscience and the law” because of lack of appropriate services. This occurred in 1773 (Deutsch, 1937).

More than 200 hundred years later, we are still faced with the same problem. The language has changed, but the issues remain. They existed in colonial Virginia; in 19th century New York, where the 1894 Lunacy Commission concluded that the presence of persons convicted of criminal offenses in civil hospitals “was very objectionable to the ordinary inmates” and, therefore, a maximum security hospital for the criminally insane should be built (Steadman and Coccozza, 1974); and today in Flathead County, Montana, where the local jail routinely accepts psychiatric emergency admissions in the absence of any criminal charges (Torrey, et al., 1992).

Over the years, various movements and reforms have attempted to solve the problem, but periodically the issue of persons with mental illnesses in our nation’s prisons and jails worsens. Policy changes over the last 30 years in both the mental health and criminal justice systems have created conditions that have exacerbated the problem of persons with mental illnesses in the criminal justice system.

Shifting Responsibilities for Mental Health Services

Over the last 30 years there have been dramatic changes in the mental health service delivery system. These include the decline of the State hospital, the growth of community mental health centers, the expansion of the use of psychiatric services in general hospitals, the transfer of large numbers of persons with severe mental illnesses to nursing homes and board and care facilities, and a dramatic rise in the numbers of persons with mental illnesses who are incarcerated or homeless.

In the past, a person with severe mental illness could expect to spend most of his or her life in a State-operated psychiatric facility. Now, persons with mental illnesses can live in the community with mental health supports. With the locus of care shifting away from inpatient services, persons with mental illnesses have access to a larger number of mental health services and providers and a wider range of programs.

These changes have not always produced positive outcomes. The reform effort known as deinstitutionalization was begun in the late 1950s and early 1960s, spurred in part by the advent of effective psychotropic medications and by changes in treatment philosophies.

During this time many long-term inpatients were released from psychiatric facilities to community-based care and living situations. At the same time, a related policy of diversion was begun that discouraged hospitalization and encouraged alternatives to inpatient care. The Federal Government, through the Community Mental Health Centers Act of 1963, reinforced these general policies by funding the development of comprehensive community-based mental health services.

In addition, the creation of the Medicaid program further promoted the shift of care from State psychiatric centers to the community, most importantly to nursing homes and general hospitals. Further, the Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) programs provided direct assistance to persons with severe mental illnesses living in the community.

One outcome of these policies was a reduction across the nation of the State hospital inpatient census from 560,000 in 1955 to 100,000 in 1989 (National Institute of Mental Health, 1991). But these changes resulted in more than simply the loss of State-operated inpatient beds. They also resulted in a blurring of fiscal and administrative responsibilities for the care of persons with severe mental illnesses and a growing fragmentation in service provision as the number and breadth of service providers, both inpatient and outpatient, increased.

Several Federally sponsored partnerships have been developed to address the fragmentation and lack of coordination among service providers and funders, including the National Institute of Mental Health Community Support Program, begun in 1978, that established a single point of responsibility within each State for the coordination and care of persons with severe mental illnesses. The Mental Health Systems Act of 1980 outlined the need for the creation of Federal/State/local alliances to develop comprehensive and coordinated community-based care for persons with severe mental illnesses.

The Changing Criminal Justice System

Funding cutbacks during the past decade have resulted in systems-level changes in the provision of mental health services. In many communities, that has meant the net reduction of services such as emergency mental health care. Certainly, inadequate funding is one factor associated with the increased numbers of persons with mental illnesses in the criminal justice system. But equally, if not more, important is the lack of *appropriate* services, and the unwillingness of many community providers to target services to those individuals with the most serious mental illnesses, including those involved with the criminal justice system (Torrey et al., 1992).

One of the consequences of the loss of 24-hour mental health emergency services is the arrest and incarceration of persons with mental illnesses in crisis. In communities with few mental health resources, jails often have become the default psychiatric facilities (Torrey, et al., 1992). Jails are open 24 hours a day, and a person who is charged with a crime cannot be refused admission regardless of his or her mental or physical condition.

While the mental health service system is struggling to develop a cost-effective model that provides care to all persons with mental illnesses, that is easy to access and negotiate, and that is accountable, bridges to other systems are also being built. Like the mental health system, the criminal justice system has also undergone major changes in recent years.

In the last decade, the U.S. jail population on any given day has increased from 158,394 to 444,584 (U.S. Department of Justice, 1993). Similarly, the prison population in the same period has increased from 329,000 to 824,133 (Bureau of Justice Statistics, 1993). Fully 2.3 percent of the U.S. adult population is in jail, in prison or on parole on any given day, giving the U.S. the world's highest incarceration rate.

Burgeoning corrections populations are a product of several policy changes in the U.S., including the generally harsher sanctions resulting from the policy of "getting tough on crime" and the more recent "war on drugs." In addition, stiffer penalties have been imposed through sentencing reform legislation.

Changing philosophies regarding the purpose and goals of punishment have led many States toward presumptive sentencing—"an offense-based sentencing system with clearly defined punishments for specific illegal activities" (Clear et al., 1993). These statutes take much of the discretionary power out of the hands of judges and place it the hands of the legislatures.

The Recent Impact of the Advocacy Movement

Presumptive sentencing statutes have been passed in 20 States (Byrne, 1992). The prison population has doubled in the last decade in large part because of reforms that require mandatory sentencing for drug, sex and driving while intoxicated offenses.

In addition, presumptive sentencing affects parole release decisions by establishing mandatory minimum lengths of incarceration for all offenses. States with these statutes must release individuals when they have served their minimum term minus time for good behavior. These persons are discharged to community supervision. In 1977, only 6 percent of the total releases to the community were supervised mandatory releases, but by 1990 this figure had grown to nearly 30 percent. At the same time, traditional discretionary parole releases dropped by 31 percent (Bureau of Justice Statistics, 1991).

Clearly, the number of jail detainees and prison inmates continues to grow at an alarming rate. This growth places an enormous strain on the resources of these institutions. At the same time, there has never been as great a need for resources to be devoted to mental health care in these facilities. Likewise, parole and probation populations are also increasing, requiring access to coordinated mental health care delivered by community providers.

Patients' rights advocates, including consumer and family groups, have been instrumental in the development of a national agenda to address the needs of persons with mental illnesses in the criminal justice system. Several of these efforts are discussed below.

Patients' Rights Litigation and the Consumer Movement

The mental patients' rights litigation and the consumer advocacy movement have their roots in the civil rights movement of the 1950s and 1960s. The political activism around the civil rights, antiwar, and women's movements was also highly critical of the role of psychiatry in preserving the status quo (Brown, 1985). The general distrust of psychiatry due to its affiliation with the "establishment" was focused and targeted by consumers/survivors. Liberation groups in the 1960s and 1970s pointed to abuses of the system exemplified by the warehousing of individuals, the excessive use of seclusion and restraints, and forced medication in State psychiatric hospitals.

Key issues in mental health advocacy litigation were the right to treatment (e.g., *Rouse v. Cameron*, *Wyatt v. Stickney*), the right to refuse treatment (e.g., *Kaimowitz v. Department of Mental Health*, *Rogers v. Okin*), safeguards on commitment proceedings (e.g., *Donaldson v. O'Connor*), and patient labor (e.g., *Souders v. Brennan*). These cases, among others, established the constitutional rights of persons with mental illnesses.

Consumer groups have grown in recent years and now play a critical role in advocacy and policy. Consumers now participate in the provision of services, including operating self-help groups, acting as protection and advocacy staff, and providing direct services as case managers and therapists. In addition, consumer groups are increasingly involved in the policy arena, conducting research and lobbying. The mental health services systems, from the Federal to the local levels, have begun to see the importance of having consumer consultants when designing services, research and policy. Consumer groups have a unique perspective on mental health services and will continue to have an impact on issues relating to persons with mental illnesses.

Family Member Advocacy Groups

Two national advocacy organizations have had a distinct impact on persons with mental illnesses in the criminal justice system: the National Alliance for the Mentally Ill (NAMI) and the National Coalition for the Mentally Ill in the Criminal Justice System (the Coalition).

Founded in 1979, NAMI is a national grassroots support and advocacy organization for the families and friends of persons with mental illnesses. This organization currently has more than 140,000 members and over 1,000 affiliate groups representing all 50 States. At the national level, NAMI provides public education and advocacy and operates a toll-free HELPLINE. In addition, NAMI has a Forensic Network that advocates on behalf of persons with mental illnesses who come into contact with the criminal justice system. Specifically, the Forensic Network provides technical assistance to families and professionals and lobbies on legislative issues on both the State and national levels.

NAMI, with the Public Citizen's Health Research Group, has sponsored a series of studies and reports on issues affecting persons with severe mental illnesses, including *Washington's Grate Society: Schizophrenics in the Shelters and on the Streets* (1985), *Fiscal Misappropriations in Programs for the Mentally Ill: A Report on Illegality and Failure of the Federal Construction Grant Program for Community Mental Health Centers* (1990), *Care of the Seriously Mentally Ill: A Rating of State Programs* (1986, 1988, 1990), and *Criminalizing the Seriously Mentally Ill: The Abuse of Jails as Mental Hospitals* (1992).

The wide distribution and prominence of this latter report, *Criminalizing the Seriously Mentally Ill*, has probably done more to focus attention on this problem than any other single document. The impetus for this report came from NAMI members who expressed frustration over the circumstances that led to the incarceration of family members and the abuses experienced by individuals with mental illnesses while in jail. The report is based on information systematically gathered from mentally ill individuals who have been in jail and their families, and a mail survey sent to all U.S. county and municipal jails. Among its most notable findings are:

- 29 percent of jails that responded hold persons with severe mental illnesses without any criminal charges;
- 20 percent of jails that responded have no mental health services; and
- 46 percent of jails that responded do not know whether persons with mental illnesses released from jail receive outpatient mental health services upon release.

The National Coalition of the Mentally Ill in the Criminal Justice System is a nonprofit organization founded in 1989 to deal with the growing national crisis of increasing numbers of individuals with mental illnesses or dual diagnoses who are in the custody of criminal justice agencies. With major support from the Center for Substance Abuse Treatment of SAMHSA, the Coalition has developed a national agenda to develop effective models for screening, diverting, and treating these individuals and to establish comprehensive community-based systems of care to facilitate their rehabilitation.

Through the use of innovative national forums on jails, prisons and the juvenile justice system, the Coalition has sought to build consensus and to design strategic solutions to the problems it addresses. Participants in these forums are corrections professionals, judges and court administrators, mental health treatment providers, legislative leaders and policy makers, families, researchers, and representatives of Federal agencies that have responsibility for the care of these individuals.

Professional Guidelines

In addition to developing a knowledge base, the Coalition disseminates the information it gathers to those who can best use it. The Coalition has developed two reports of importance to this field, *Responding to the Mental Health Needs of Youth in the Juvenile Justice System* (1992), and *Mental Illness in America's Prisons*. (1993). Both of these reports present information on state-of-the-art interventions to effectively treat or divert persons with mental illnesses who come into contact with the criminal justice system.

The movement to improve conditions in jails and prisons has been accompanied by a commitment to the improvement of health and mental health care. The genesis for the development of standards of care came not from administrators nor from State or Federal government, but rather from professional organizations. The first organization to publish standards of care for jails and prisons was the American Public Health Association (APHA).

In 1976, APHA published *Standards for Health Services in Correctional Institutions*. While devoted primarily to general medical care, the standards contained six principles for adequate mental health care, and represented an important first step toward the development of comprehensive mental health standards. The American Medical Association (AMA) published standards for health services for prisons in 1979 and for jails in 1981. A separate draft of mental health standards was also developed at this time, but was not promulgated.

The first comprehensive standards for mental health care in correctional settings were developed by the National Commission on Correctional Health Care. The Commission was composed of 28 professional organizations, including the AMA, the American Bar Association, the American Psychiatric Association (APA), and the National Sheriffs Association. In 1987, the Commission updated the AMA standards. This organization's primary purpose is to accredit prison and jail services, and the group also focuses on education, training, and research.

In 1982, the APA created a Task Force on Psychiatric Services in Correctional Facilities to address the specific need for mental health standards. In 1989, the APA published the most comprehensive set of mental health standards for jails and prisons that currently exists. Many of the core principles and essential services discussed throughout this report come directly from the APA guidelines.

The Legal Context

Providing mental health care to persons in the criminal justice system makes sense from a humanitarian, as well as from a correctional management perspective. However, even in the absence of these necessities, jails and prisons have a substantial constitutional obligation to provide a minimum standard of care. The following discussion draws heavily on a review of case law by Cohen and Dvoskin (1992).

While the constitutional grounds for the rights of individuals differ for convicted inmates and unconvicted detainees, what constitutes adequate care is essentially the same. Thus, while the protection of vulnerable inmates and the proactive treatment of an identified serious psychiatric disorder are required under Federal law, other issues such as staff training, who provides the service and where, the treatment modality, administration of the jail and treatment staff, and reimbursement or payment methods are local and State decisions.

Cohen and Dvoskin (1992) state, "While the legal source of the right to treatment for inmates and detainees differs (cruel and unusual punishment v. due process), the case law makes no substantive distinctions in terms of what must be provided. Obviously, there are differences in service delivery systems; for example, jails experience more short-term crises and suicides, and fiscal and administrative relationships may vary. However, when the courts address what types of conditions entitle which persons in confinement to what type of medical or psychiatric care, the substantive entitlements are essentially the same."

Custodial facilities have both the duty to protect and the duty to treat a serious medical or psychiatric condition. Case law in this area has defined the extent of these duties as they affect persons with mental illnesses.

Duty to protect requires a facility to provide safeguards so that the inmate/detainee is no worse off in custody than he or she was upon arrival. In addition to protection from physical and sexual assault, this also requires that the facility protect the individual from himself or herself. This includes suicide prevention and early identification and crisis intervention services to keep the individual's condition from deteriorating.

In addition, the **duty to treat** requires that the custodial facility attempt to alleviate known suffering. Once an individual is known to be suffering from a severe mental illness, the facility is required to intervene through appropriate staff and treatments as determined by general professional standards.

A case in New York, *Langley v. Coughlin*, actually provides a list of the specific claims that would indicate inadequate mental health care, and, in conjunction with deliberate indifference, could justify a conclusion that an individual's rights were violated under the Eighth and Fourteenth Amendments (Cohen and Dvoskin, 1992):

- Failure to take a complete medical (or psychiatric) record.
- Failure to keep adequate records.
- Failure to respond to inmates' psychiatric history.
- Failure to at least observe inmates suffering a mental health crisis.
- Failure to properly diagnose mental conditions.
- Failure to properly prescribe medications.
- Failure to provide meaningful treatment other than drugs.
- Failure to explain treatment refusal, diagnosis, and ending of treatment.
- Seemingly cavalier refusals to consider bizarre behavior as mental illness even when a prior diagnosis existed.
- Personnel doing things for which they are not trained.

Clearly, case law indicates that the provision of mental health services to persons with mental illnesses who come into contact with the criminal justice system is not a luxury, but a constitutional necessity.

A Diverse Population

Further complicating the provision of mental health services to persons in the criminal justice system is the heterogeneous nature of the population and the needs of such special groups as women, persons of color, youth, and persons with HIV/AIDS or other dual disorders. The characteristics of individuals with mental illnesses who come into contact with the criminal justice system, and a discussion of their special needs, are discussed in Chapter Three.

CHAPTER 3

The Nature of the Population

A Diverse Group People come into contact with the criminal justice system for many reasons. Only a small portion of them have acute mental disorders, but this group demands disproportionate attention, both because of their special needs and because of the problems they pose for law enforcement and corrections personnel and for the proper administration of the criminal justice system.

Persons with mental disorders are a heterogeneous group. The effects of their mental illnesses range from psychosis, to severe disruptions in emotions, to functional impairments in the ability to relate to others or sustain work. They represent different ages, gender, cultural and ethnic backgrounds, and sexual preferences. They have a wide range of experiences and abilities, and they live in metropolitan, suburban and rural areas. A few have been violent; most have not. All of these factors must be considered when developing mental health programs in the community and in the criminal justice system.

Clearly, there is an overrepresentation of men and persons of color, particularly African Americans, in correctional facilities. Men represent more than 90 percent of the jail and prison populations in the United States. Further, nearly half of all persons in U.S. jails and prisons are African American, while persons of Hispanic descent represent 14 percent and 17 percent of jail and prison populations, respectively (Bureau of Justice Statistics, 1993).

The magnitude of this overrepresentation is clear when one considers that only 11 percent of the U.S. population in 1989 was African American, and all other non-White, non-European ethnic/racial groups composed 3 percent of the U.S. population (U.S. Department of Health and Human Services, 1993). This fact, alone, has implications for mental health services provision within the criminal justice system in regard to such fundamental issues as language and cultural diversity. In addition, some groups, such as women and persons with HIV/AIDS, though representing only a small percentage of the whole population, will require a disproportionate amount of attention to their special needs.

Most Persons with Mental Illnesses Are Not Violent

The current diagnostic manual of the American Psychiatric Association, *The Diagnostic and Statistical Manual of Mental Disorders, Third Edition - Revised (DSM-III-R)*, lists approximately 300 identifiable disorders. These disorders vary greatly according to the degree of functional impairment, etiology, symptomatology, prognosis and associated treatment interventions. The degree of distress and the ability to adapt to situations will differ depending on both the type and severity of the mental disorder.

This report focuses on *adults* with mental disorders defined by CMHS as:

someone who currently or at any time during the past year [has] had a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-III-R, that resulted in functional impairments which substantially interferes with or limits one or more major life activities (Mental Health Report, June 3, 1993).

Many mental illnesses follow a cyclical course, allowing individuals to achieve or return to extremely high levels of functioning during periods of remission. With treatment and supports provided on a regular basis, most persons with mental illnesses can function well in community settings.

The belief in a strong link between violence and mental illness is firmly rooted in the minds of many U.S. citizens. It is important to evaluate this belief objectively because beliefs drive both formal policies and laws and behavior toward persons with mental illnesses, and, if such a link does exist and can be specified, program models and interventions can be designed and implemented.

In fact, **most** people with mental illnesses are no more likely to be violent than any other member of the community. However, **some** individuals, as a result of their mental illnesses at certain times, do present a greater risk. Researchers have found that violent behavior is directly linked to psychotic symptoms regardless of whether the individual has ever received mental health services (Link, 1992), and that persons currently experiencing psychotic symptoms may be at increased risk of violence (Monahan, 1993).

The recent National Institute of Mental Health Epidemiological Catchment Area study revealed that 90 percent of persons with current mental illnesses are not violent. This fact alone refutes the dominant media representation of most persons with mental illnesses. In fact, violent behavior of persons with mental illnesses represents only a minor contribution to all violent crimes. Monahan (1992) states that:

“compared with the magnitude of risk associated with the combination of male gender, young age, and lower socioeconomic status, for example, the risk of violence presented by mental disorder is modest. Compared with the magnitude of risk associated with alcoholism and other drug abuse, the risk associated with major mental disorders such as schizophrenia and affective disorder is modest indeed. Clearly, mental health status makes at best a trivial contribution to the overall level of violence in society.”

For those who might become violent during acute episodes of mental illness, several alternatives are possible. For example, such approaches as conditional release and outpatient commitment should be considered as a way to compel cooperation with a service plan for those persons who might become violent when they do not comply with treatment.

In addition, Intensive Case Management programs have shown considerable promise for helping this population (Dvoskin and Steadman, 1994), and brief inpatient treatment or crisis stabilization services may also be warranted (Task Force on Homelessness and Severe Mental Illness, 1992). Clearly appropriate legal protections for persons receiving various forms of community supervision are necessary so that individuals' rights are properly balanced with the community's right to protection.

To the degree that these services are available, persons with mental illnesses pose no greater threat to the community than other individuals. If these elements are not in place, some persons with mental illnesses may commit violent acts that could lead to their arrest.

Consensus Statement on Violence and Mental Disorder: Public Perceptions vs. Research Findings

This statement was drafted by the John D. and Catherine T. MacArthur Foundation Research Network on Mental Health and the Law, under the direction of John Monahan, Ph.D., in collaboration with the National Stigma Clearinghouse.

“Mental disorder” and violence are closely linked in the public mind. A combination of factors promotes this perception: sensationalized reporting by the media whenever a violent act is committed by a “former mental patient,” popular misuse of psychiatric terms (such as “psychotic” and “psychopathic”), and exploitation of stock formulas and narrow stereotypes by the entertainment industry. The public justifies its fear and rejection of people labeled “mentally ill,” and attempts to segregate them in the community, by this assumption of “dangerousness.”

The experience of people with psychiatric conditions and of their family members paints a picture dramatically different from the stereotype. The results of several recent large-scale research projects conclude that only a weak association between mental disorders and violence exists in the community. Serious violence by people with major mental disorders appears concentrated in a small fraction of the total number, and especially those who use alcohol and other drugs. Mental disorders—in sharp contrast to alcohol and drug abuse—account for a miniscule portion of the violence that afflicts American society.

The conclusions of those who use mental health services and of their family members, and the observations of researchers, suggest that the way to reduce whatever relationship exists between violence and mental disorder is to make accessible a range of quality treatments including peer-based programs, and to eliminate the stigma and discrimination that discourage, sometimes provoke, and penalize those who seek and receive help for disabling mental health conditions.

May 31, 1994

Persons with Special Needs

Persons with mental illnesses who come into contact with the criminal justice system have special needs, as compared to other detainees. Yet even within this group of persons with mental illnesses, there are subgroups that warrant particular attention. These include persons with co-occurring substance use disorders, women, ethnic and racial minorities, homeless persons, persons with HIV/AIDS, and youth. The needs of each of these special groups are described in brief below.

Persons with Co-occurring Substance Use Disorders

It is well known that there is a high incidence of substance use disorders among inmates in U.S. jails and prisons. Between 60 and 70 percent of U.S. jail detainees have a history of substance abuse (American Jail Association, 1992). A 1991 Department of Justice report found that 78 percent of the surveyed inmates reported having used substances of some kind, excluding alcohol. And 56 percent were under the influence of drugs or alcohol at the time of their arrest.

Abrams and Teplin (1991) demonstrated a high prevalence of co-occurring disorders, as well. In a random sample of male jail detainees in Cook County, IL, the lifetime prevalence rate of co-occurring severe mental illness (including schizophrenia, mania, or major depression) and alcohol or drug abuse or dependence disorders was 72 percent.

Persons with co-occurring disorders have special treatment needs. For example, such individuals may need to take psychotropic medications to control psychiatric symptoms, while many substance abuse interventions require abstinence from all drugs. In addition, symptoms of mental illnesses and of substance toxicity often appear similar, making it difficult for individuals to receive accurate diagnoses and treatment plans.

There are few treatment programs for individuals with dual diagnoses in local communities or within State and Federal correctional systems. In most State prison systems, for example, persons receive services from either mental health or substance abuse programs. In some communities, there is an increasing emphasis on developing integrated mental health and substance abuse treatment models for persons with dual disorders (CMHS, 1993). Such programs need to include a focus on staff training to help providers in the mental health, substance abuse, and criminal justice systems accurately recognize and treat persons with dual disorders.

Women

Although women represent only a small percentage of jail and prison inmates, between 5 and 10 percent, studies show they are more likely than incarcerated men to have severe mental illnesses (Teplin, unpublished; Rice and Harris, 1993). They are also more likely than men to be diagnosed with an affective disorder, which is easier to overlook since it is less often associated with disruptive behavior.

Compounding the problems of women with mental illnesses in the criminal justice system are issues that are not common or are non-existent among men. Among these concerns that may require special attention are pregnancy and primary responsibility for minor children, a history of domestic violence and early childhood physical or sexual abuse, and inadequate mental health treatment and housing in jails and prisons.

In 1991, 67 percent of women in prisons had one or more children under 18, and 6 percent of all women who entered prison that year were pregnant. This represents 56,000 minor children for the 38,462 women incarcerated in U.S. prisons. Approximately 70 percent of these women lived with their minor children prior to being incarcerated (Bureau of Justice Statistics, 1993).

Some women who are pregnant or who have minor children will also have mental illnesses, and women separated from children or who are pregnant are under increased stress and may require mental health services targeted specifically to these issues. These additional stresses often can be reduced by policies in jails and prisons that allow children to visit and programs that offer parenting courses.

Mental health and substance abuse treatment programs that are offered to women in jails and prisons may need to assess and provide additional services to women with histories of physical or sexual abuse. Among persons with mental illnesses in general, women are more likely than men to be victims of abuse, particularly sexual abuse (Carmen, Rieker, and Mills, 1984; Jacobson and Richardson, 1987).

In addition, histories of abuse are common among incarcerated women. Rann (1993) found that 50 percent of female Michigan jail detainees had been victims of physical or sexual abuse at some point in their lives. More than 70 percent of women with drug or alcohol abuse problems were victims of violence, including domestic assault by adult partners, rape and incest (National Council on Alcoholism, 1990).

Because women represent a small proportion of jail and prison populations, many facilities do not provide a full range of mental health services, or appropriate housing options, for female inmates/detainees. Further, services that are offered are often based on the needs of men.

Ethnic and Racial Minorities

Ethnic and racial minorities, particularly African-American and Hispanic individuals, are overrepresented in U.S. jails and prisons, comprising 57 percent of jail populations and 65 percent of prison inmates (Bureau of Justice Statistics, 1993). Mental health programs for such individuals must be designed and implemented based on the cultural experiences of the persons they are meant to serve. Mental health and correctional staff should be trained to be sensitive to cultural issues and, to the extent possible, should reflect the demographic mix of the population.

Persons Who Are Homeless

Persons with mental illnesses who are homeless are among the most likely individuals to be arrested, and incarceration, rather than release on bond, increases the probability that persons with mental illnesses will be homeless upon release (Dennis and Steadman, 1991).

Arrest rates for homeless persons with mental illnesses range from 20 to 75 percent, and the majority of these individuals are arrested for “trivial, victimless, and non-violent offenses” (Dennis and Steadman, 1991). Many homeless people who commit minor crimes do so in order to obtain basic necessities, such as shelter, food and medical care.

Teplin (1987) notes that arrest is often the only disposition available to police in situations where persons are not sufficiently disturbed to warrant hospitalization, but too ill to be ignored. Release on one’s own recognizance or low bail is less likely if the detainee is known to be undomiciled.

Typically, neither the mental health or criminal justice systems are prepared to meet the full range of mental health, housing, and support needs of persons with mental illnesses who are homeless. Gelberg and colleagues (1988) recommend that mental health, drug and alcohol treatment, housing programs, and social services be provided *in a single, coordinated setting* for homeless persons with mental illnesses who have committed minor offenses.

Persons with HIV/AIDS

In 1991, 51 percent of State and Federal prison inmates had been tested for the human immunodeficiency virus (HIV). Overall, 2.2 percent were found to be HIV positive, with women, African-American, and Hispanic inmates more likely than Caucasian men to carry the virus that causes AIDS.

Persons with mental illnesses may be particularly vulnerable to HIV/AIDS, and individuals with advanced cases of AIDS may experience organically based psychiatric disorders (Evans and Perkins, 1990). In addition to the dementia accompanying the disease process itself, suicide and suicidal ideation, depression, and anxiety may also occur.

Clearly, inmates with HIV/AIDS must have access to a full range of health and mental health care, including psychosocial and pharmacological interventions and AIDS-specific counseling and support services. Such specialized services are helpful not only to persons coping with the disease, but also in promoting HIV risk reduction for uninfected persons (National Institute of Justice, 1993).

While many correctional systems offer special counseling, housing and services to inmates with HIV/AIDS, these programs are often understaffed, sharing mental health professionals with more generic caseloads. To meet the mental health needs of inmates with AIDS, more than half of State and Federal prison facilities sponsor peer counseling and support programs. They also report using community AIDS service organizations to provide individualized counseling and support within their facilities and to help parolees and others coming out of prison obtain needed services.

Youth

The juvenile justice system is a completely separate network of courts, facilities, and service agencies from the adult system. The needs of juveniles with mental illnesses in the juvenile justice system are extremely important, and cannot be covered adequately in the scope of this report, which focuses on adults. However, one issue that does merit mention is the treatment of youth who are waived into adult courts.

In 1991, 1 percent of inmates in State correctional facilities were 17 years old or younger (Bureau of Justice Statistics, 1993). Youth in the criminal justice system have higher rates of mental illness than youth in the general population (Otto et al., 1992). They are more likely to have conduct, attention deficit, anxiety, and affective disorders than psychotic disorders, with conduct disorders and depression more common among adolescents, and anxiety disorders more prevalent among younger children (Costello, 1989).

Young persons with mental illnesses bound over in adult facilities present several mental health issues to adult correctional facilities. Because of their youth and their mental disabilities, they are at increased risk of sexual and physical abuse by other inmates. Programs for youth in adult facilities should attend to the kinds of mental disorders common among youth, be tailored to the interests and problems of adolescents, and address the special problems of victimization. Comprehensive and integrated family-oriented services in the community can help divert youth from the criminal justice system.

Needed Services

Just as persons with mental illnesses have diverse needs, so too will those needs vary depending on the point at which they come into contact with the criminal justice system. A person whose acute psychiatric crisis brings him or her to the attention of the police may need immediate stabilization, while a prison inmate with severe mental illness will likely require ongoing treatment and support.

And the responsibilities of the criminal justice system for persons with mental illnesses will differ at each stage, as well. An individual may be detained in jail for a short period of time, so that jail staff may focus primarily on maintaining continuity of any community-based services the person is receiving. Personnel responsible for individuals with mental illnesses on probation or parole in the community may act as case managers to broker a full range of health, mental health, housing, and social services for their clients.

These distinctions — the varying needs of persons with mental illnesses at different stages of the criminal justice system, and the differing responsibilities of the criminal justice system for persons with mental illnesses in their charge — are explained in Chapter Four.

CHAPTER 4

Defining the Needs of Persons with Mental Illnesses in the Criminal Justice System

Background

There are numerous points at which individuals with mental illnesses may come into contact with the criminal justice system. They may be arrested by the police, held for a short period of time in a lockup or local jail, serve a sentence in prison, or be supervised on probation or parole in the community after detention in jails or prisons. Each of these points in the system will be described in this chapter, with special emphasis on the needs of persons with mental illnesses at each point and the responsibilities of the criminal justice system for the individuals in their care. Special challenges at each stage will be highlighted.

Table 4.1 displays the points of contact in the criminal justice system, the primary related mental health treatment issues, and the key services that ideally should be available at each level. As indicated in Table 4.1, the primary decision for law enforcement officers is to arrest or to transport an individual to a mental health facility and attempt to get him or her into treatment. Services that make this choice possible include the availability and accessibility of 24-hour emergency mental health treatment, mobile crisis teams that can assist in the resolution of the incident, transportation, and staff who can wait with an individual for an evaluation.

The primary issue in both lockups and jails is the safety of the detainee, other inmates and custodial staff. Inmates are briefly held pre-arraignment, after not meeting bail, or while serving sentences of less than one year. Half of all inmates leave within 24 hours. Key services at this point include identification of persons with mental illnesses through routine screening and follow-up evaluations, and stabilization of the individual through crisis intervention services. In addition, to facilitate the movement of persons with mental illnesses back into the community or to a prison setting, discharge planning and case management services are important.

Prisons are contained communities, where inmates spend a considerable amount of time. Inmates with mental illnesses, like persons with mental illnesses in the general community, have the right to treatment to improve the quality of their lives and to allow them to serve their time humanely. The optimum level of available services should duplicate the best that is available in the community; there should be a full range of inpatient and outpatient treatments and modalities available to all inmates.

TABLE 4.1

**Points of Criminal Justice Contact and
Primary Mental Health Treatment Goals**

Location	Main Treatment Issues	Key Mental Health Services
Police	Arrest or diversion to mental health treatment	Emergency MH services Mobile crisis teams Transportation
Lockup	Safety of detainee, other inmates and staff	Screening Evaluation Crisis intervention
Jail	Safety of detainee, other inmates and staff	Screening Evaluation Crisis intervention Discharge/transfer planning
Prison	Do sentence time humanely Maximize participation in prison programs and community	Screening Evaluation Crisis intervention Long-term treatment Special non-medical housing Discharge/transfer planning
Community Supervision (1) Probation (2) Parole	Maintain individual in the community Protect the community	Access to a full range of community-based mental health services

Similar to the prison, persons under community supervision (i.e., probation or parole) need a full range of mental health services available for their use. These services should help to maintain persons with mental illnesses in the community and, to the degree that symptomatology is kept to a minimum and that the mental disorder was linked to criminal behavior in the past, to reduce the risks of recidivism.

An issue that often surfaces in discussions of mental health services in correctional settings is the conflict between treatment and security, or therapy versus custody. Often it is taken as a given that the respective ideologies of the criminal justice and mental health systems are inherently contradictory and will produce conflicts wherever the two intersect (see Steadman et al., 1985 for a review of the literature).

However, Steadman and colleagues (1985), in a study of 43 U.S. jail mental health programs, found that fundamental conflicts between mental health and corrections staff were not frequent. In providing for the safety of detainees and inmates with mental illnesses, other detainees and inmates, and custodial staff, the goals of mental health treatment and corrections actually converge. Accordingly, corrections staff believe that appropriate mental health interventions can help them to do their job better.

Police as Frontline Mental Health Decision Makers

Law enforcement officers are frequently the first providers in the criminal justice system to have contact with a person with mental illness. In addition to their role as peace keepers and crime fighters, police spend a considerable amount of time assisting citizens and mediating disputes. The police officer has been described in the literature as “philosopher, guide and friend” and “amateur social worker” (Cumming et al., 1966), “streetcorner psychiatrist” (Teplin and Pruett, 1992), and “psychiatrist in blue” (Menziés, 1987).

There are several ways that persons with mental illnesses come to the attention of police officers. They may be the object of a call involving a citizen or business complaint, an officer may observe them acting in an inappropriate, bizarre, or criminal manner, or police may have a court order or warrant for an emergency psychiatric apprehension. In addition, police receive calls from persons with mental illnesses requesting assistance.

In a study of mental health calls to police in a Denver suburb, 50 percent of contacts were calls from friends or relatives requesting police assistance for noncriminal activity, 30 percent were calls from persons with mental illnesses, 17 percent were calls from community members who did not know the individual personally, and 3 percent were police observation (Pogrebin, 1986-87). Another study revealed that of all police contacts with citizens, excluding traffic violations, 4 percent involved persons with suspected mental illnesses. Of these, 65 percent were noncriminal and 35 percent were suspects in a crime (Teplin and Pruett, 1992).

Making Difficult Decisions

Despite the small percentages of complaints that involve persons with mental illnesses, these can be difficult cases for police to handle. There has always been an inherent conflict for officers in how to best serve the needs of the community and the needs of the individual with mental illness. Law enforcement officers are often not sure how best to help.

In general, police officers feel competent to determine whether an individual meets the legal criteria for emergency psychiatric detention (Gillig et al., 1990). Nonetheless, while officers may feel confident they can identify severe psychotic disorders, it is not clear that they are well trained to identify other serious disorders, such as bi-polar or major depression.

Police may be unfamiliar with what mental health services and facilities are available in the community and how to contact them. Some communities lack needed mental health facilities, while existing agencies often have limited space for police referrals, restrictive admission criteria, complicated admissions procedures, and prohibitive financial requirements. In addition, the need for a mental health agency to restrict confidential information about a client may conflict with the law enforcement officer's job of trying to decide on the best disposition for a particular individual.

While emergency stabilization of an individual may be a high priority, some communities do not have 24-hour services or mobile crisis teams. Often the only options available to police in lieu of arrest are transportation to a community mental health center during the hours it operates or to a general hospital emergency room that may be reluctant to take problem cases (Steadman, 1990). Transportation of persons with mental illnesses can take a considerable amount of an officer's time, and if the facility will not or cannot take the individual due to commitment laws or the unavailability of beds, the problem remains unsolved. The officer must then decide whether to arrest or release the individual.

Today, as in the past, police are reluctant to arrest persons with mental illnesses who commit minor crimes or are creating a disturbance. They also are reluctant to have the individual hospitalized, if informal options are available, such as transportation to the individual's family (Cumming et al, 1966).

While a psychiatric hospitalization is preferred to arrest, many officers will get a signed complaint so that, if the facility refuses to admit the person, an arrest can be made. Arrest is the solution of last resort. "The police will arrest rather than hospitalize the majority of mentally disordered persons who commit misdemeanors when they have prior knowledge that the person will be released in a very short period of time due to the shortage of beds at the medical facility, or that the person's behavior will probably not satisfy commitment criteria. In these instances, police will put the person in jail where they know they will be removed from the community" (Pogrebin, 1986-87:68).

Further, disposition decisions are often based on how long each alternative will take. Psychiatric hospitalization becomes a less attractive alternative in places that have lengthy waits for evaluation.

Officers are clear regarding what assistance they want from the mental health system in order to perform their duties. Once a problem has been identified, proper resolution requires information and, sometimes, assistance. Officers state that the most helpful information they can have in their encounters with persons with mental illnesses is knowledge of any prior history of psychiatric and substance abuse problems, including the potential for dangerousness or suicide, and information about current psychiatric status, including whether individuals are currently in treatment and where (Gillig et al. 1990).

In addition, consultation with community mental health professionals and availability of mobile mental health crisis teams that can respond within 15 minutes of a request have also been noted as important services (Gillig et al. 1990). Open lines of communication between the police and the mental health system and formal avenues for response will help law enforcement officials meet their twin goals of protecting the public and helping persons with mental illnesses they are called on to aid.

Lockups and Jails as Community Institutions

After an arrest is made, an individual will be held in a lockup and possibly a jail. A lockup is "usually a holding facility operated by police or other law enforcement agencies where arrestees are held while booking and other prearrest processes are being completed" (Reed 1987). They rarely keep detainees beyond 24 hours except over weekends.

Jails differ from lockups in that they are places where postarrestment inmates are detained, and are usually operated by the sheriff's office or the municipal correctional agency. The U.S. Department of Justice (1980) defines a jail as "a locally administered confinement facility with authorization to hold persons awaiting adjudication and/or those committed after adjudication to serve sentences of one year or less."

In 1991, there were approximately 3,353 jails in the U.S., ranging in size from 50 inmates or less (59 percent of all jails in the U.S.) to 1,000 or more inmates. Jails with rated capacities of 250 or more (10 percent of all U.S. jails) house 63 percent of all jail detainees (United States Department of Justice, 1990).

Most jail inmates are men (91 percent), and 57 percent are African-American, Hispanic, or members of other racial and ethnic groups. Fifty-one percent of jail inmates are unconvicted (United States Department of Justice, 1991).

Jail overcrowding is at epidemic proportions throughout the U.S. Not only are large numbers of jails antiquated and barely able to meet minimal standards of care, but also jail populations are exploding.

From 1980 to 1992, the number of persons in jail on any given day in the United States increased from 158,394 to 444,584 (Bureau of Justice Statistics, 1993). In 1990, jails were functioning at 111 percent capacity overall. And 142 jurisdictions (28 percent of all jurisdictions containing jails with 100 or more capacity) had at least one jail under court order to reduce inmate population (United States Department of Justice, 1992).

Among the burgeoning populations in U.S. jails are large numbers of persons with mental illnesses (see Table 4.2). A recent survey of a random sample of male jail admissions in Cook County, IL, found that 6 percent had a current psychotic illness and were in need of treatment services (Teplin, 1994). Among female Cook County detainees, the estimates of mental illness were even higher. Fully 15 percent of the female detainees had a diagnosis of schizophrenia or affective disorder and had an acute episode within six months prior to arrest (Teplin et al., unpublished).

TABLE 4.2

**Prevalence of Severe Mental Disorder
Among the General Population and Jail Detainees**

	Major Depression	Schizophrenia	Mania	Any Severe Disorder
General Population*	1.1%	0.9%	0.1%	1.8%
Male Jail Detainees**	3.4%	3.0%	1.2%	6.1%
Female Jail Detainees ***	13.7%	1.8%	2.2%	15.0%

* From Teplin, L.A. 1990. "The Prevalence of Severe Mental Disorder Among Male Urban Jail Detainees." *American Journal of Public Health*, 80:663-669.

** Updated from Teplin, L.A. 1994. "Psychiatric and Substance Abuse Disorders Among Male Urban Jail Detainees." *American Journal of Public Health*, 84(2):290-293.

*** Teplin, L.A., Abram, K.M. and McClelland, G.M. 1995. "The Prevalence of Psychiatric Disorder Among Incarcerated Women: I. Pretrial Jail Detainees." Unpublished.

On a national level, this would indicate that annually, approximately 700,000 admissions to U.S. jails are individuals with acute and severe mental illnesses. An additional 10 to 15 percent of inmates have mental health problems that put them at risk due to the nature and stress of the environment.

Mental Health Services in Jails

On the average, individuals spend very short periods of time in jail. During this time, the jail is attempting to perform its custodial function of safe pretrial detention while addressing the mental health problems of individuals whose access to care is highly restricted.

Often, when a person is detained, he or she is not evaluated for mental health problems, or these problems are masked by drug or alcohol intoxication. This can result in an interruption of services that the detainee may have been receiving in the community and lead to an exacerbation of his or her symptoms. In the same way, after an inmate is stabilized in the jail, lack of discharge planning, including referral to mental health treatment, social services and housing, will leave the inmate, again, without necessary supports.

To establish appropriate services for persons with mental illnesses who are detained requires that the jail be seen as but one agency in a continuum of community services (Steadman et al., 1990). Although the jail exists as a separate entity, its primary function is "processing people," and it is best characterized by its interaction with other relevant criminal justice agencies, including the police, the courts, the legal community (defense and district attorneys), and, ultimately, community services. It is important to highlight this "systemic" aspect of the jail and to approach mental health services issues in such a fashion.

Except for the largest jails, it is impractical to consider developing a comprehensive set of mental health services within a jail. This is warranted neither on the basis of need nor in terms of the dollars or physical space available. It is far more practical for the jail to make effective use of such local services as community mental health centers, psychiatric units of general hospitals, private practitioners, university departments of psychology, medicine, and social work, and State mental hospitals. "Effective use" does not necessarily mean actually transferring inmates, but does mean capitalizing on the expertise of the staffs of these programs and planning services in ways that share program resources.

Over the past decade, direct governmental expenditures for corrections have increased by 216 percent (United States Department of Justice, 1991). Despite this increase in expenditures and the expansion of physical plants, at the end of 1990, State prisons were operating at 18 to 29 percent over capacity, while Federal institutions were 51 percent over capacity.

In 1991, 95 percent of the U.S. prison population was male, and 32 percent was over the age of 35. Even though only a small minority of inmates are female, the proportion of women continues to grow. Sixty-five percent of the population is African-American, Hispanic, or other racial and ethnic groups.

Of the most serious charges, 47 percent of U.S. prison inmates were serving time for a violent offense, 25 percent for property offenses, 21 percent for drug offenses and 7 percent for public order or other minor offenses (Bureau of Justice Statistics, 1993).

Level of Mental Health Service Need

Clearly, the prison population is different from the jail population in terms of seriousness of offense and length of confinement. However, like jails, a sizable portion of prison inmates have mental illnesses. Estimates of severe mental disorders among prison inmates generally range from 6 to 15 percent (Monahan and Steadman, 1983; Steadman and Coccozza, 1993).

In addition, co-morbidity is an important factor in the management of persons with mental illnesses in prison. While arrests for all crimes have increased by 28 percent over the past decade, arrests for drug related crimes have increased by 126 percent (United States Department of Justice, 1991). As of 1991, 45 percent of U.S. prison inmates were serving time for drug offenses. Further, 79 percent stated that they had used drugs, excluding alcohol, in the past, and 62 percent said they used drugs on a regular basis

The increase in the number of drug arrests has exacerbated the problem of prison overcrowding and contributed to an increase in the number of inmates with communicable diseases, including HIV/AIDS, tuberculosis, and hepatitis. These factors, combined with insufficient programs to treat substance abuse, complicate the provision of mental health services to prison inmates. Health and mental health interventions must focus on treating individuals with multiple problems.

“Community Mental Health” in Prisons

The prison is its own full-fledged community, albeit a contained one. People eat, sleep and work there 24 hours a day. It has its own social networks and subgroups, its own religious communities, and its own educational systems.

For this reason, it is useful to conceive of prison mental health in the context of providing a “community mental health system for each prison” (Cohen and Dvoskin, 1992). This conceptualization is crucial to the planning of appropriate, cost-effective mental health services for prison inmates.

The mental health issues of prison inmates, in fact, closely parallel those of persons in the community. Since most inmates have been in the criminal justice system for some time prior to transfer to prison, acute psychiatric problems are not usually the predominant concern.

Prison inmates with mental illnesses need intermediate and long-term care. Because severe mental illnesses tend to be cyclical and episodic in nature, the needs of inmates with these disorders will vary greatly over the time they are incarcerated. Reflecting the community mental health model, the American Psychiatric Association (1989) contends that essential prison mental health services include mental health screening, evaluation, crisis intervention, treatment, and discharge/transfer planning.

In reviewing mental health services use by inmates in State adult correctional facilities, a 1988 Center for Mental Health Services report found that 2.5 percent were receiving 24-hour psychiatric inpatient treatment or residential services *within the prison setting*, 10 percent were receiving counseling or psychotherapy from a mental health professional, 5 percent were receiving psychotropic medications, and 4 percent had a psychiatric assessment or evaluation completed during the study month (these percentages reflect a duplicated count).

Of course, not all inmates with mental health needs are receiving services (General Accounting Office, 1991). More than half of the Federal facilities surveyed stated that they had some inmates whose mental health had not been diagnosed.

Probation and Parole: Uncharted Territory

The failure to diagnose inmates with mental health service needs was due to in part to inmates' ability to successfully function in the general prison population, and to inadequate screening procedures allowing some individuals with mental illnesses to go unrecognized. Further, many inmates diagnosed as being in need of treatment were not receiving any because they refused services or there was a lack of available mental health resources. Better and more uniform methods of identifying persons with mental health needs and the further development of mental health services can help insure that all prison inmates who need and want such services receive them.

Clearly, persons with mental illnesses, regardless of whether they are prisoners or not, sometimes require inpatient care. The provision of both inpatient and outpatient services within the prison setting facilitates the integration of inmates with mental illnesses in the general prison population.

After jail or in lieu of jail, persons may be supervised by probation departments. Similarly, community supervision by parole departments often follows release from prison.

Like jail and prison populations, the number of persons who are under supervision by probation and parole departments has increased dramatically in the past decade. As of December 31, 1990, there were 2,670,234 persons supervised by probation departments and 531,406 individuals supervised by parole departments, representing one-year increases in those populations of 5.9 percent and 16.3 percent, respectively (Bureau of Justice Statistics, 1993). Overall an estimated 3 million adults or 1.7 percent of the adult population in on probation or parole.

The percent of persons under community supervision through probation or parole who have mental illnesses is unknown. However, based on prevalence rates of mental disorders for jail admissions and data on prison inmates, it can be assumed that the rate of mental disorders among parolees and probationers is two to three times higher than that of the general population. Given the prevalence of mental illnesses in jails and prisons and the fact that many serious disorders are undertreated or untreated, it is clear that a significant proportion of parolees and probationers require a range of mental health services in the community.

Probation

Criminal defendants who reach the sentencing stage in adjudication have plead or been found guilty of a crime. Sentences may take several forms, including incarceration in a jail or prison, fines or community service, and probation. The American Bar Association (1970) defines probation as "... a sentence not involving confinement which imposes conditions and retains authority in the sentencing court to modify the conditions of sentence or to resentence the offender if he violates the conditions. A sentence to probation should be treated as a final judgement for purposes of appeal and similar procedural purposes."

Probation sentences can be applied to felonies, as well as misdemeanors. Individuals may be sentenced to probation only, or probation may be one part of a sentence that also includes incarceration. About 40 percent of probation cases are split sentences, with 75 percent involving a median 6-month jail term, followed by three years of probation, and 25 percent entailing a median four-year jail term, followed by three years of probation (Dawson, 1990).

There are three types of conditions that can be applied to a probation sentence: (1) standard conditions applied to all probationers, such as reporting regularly and notifying the probation office of a change of address; (2) punitive conditions, including paying fines or performing community service; and (3) treatment conditions that are imposed to address special needs of the individual, such as substance abuse or mental health treatment.

In the past 20 years, the focus of probation has changed from rehabilitation within a medical/social work model to risk management and brokering of services. The earlier model stressed that probation officers provide direct services such as counseling, much like a social worker. More recently, the role of the probation officer is much more that of a corrections officer. Special services are brokered through the officer, but not provided by him or her.

Typically, the probation officer refers individuals to specialized community services, such as mental health and substance abuse treatment, that are available to all members of the community. The probation officer's role as broker is critical, because community programs are often reluctant to accept persons who are involved with the criminal justice system and who may be participating involuntarily.

In addition to brokering services, some probation departments have provided treatment programs through the probation agency itself. While persons receiving services from generic community agencies tend to have higher rates of technical violations of their conditions of probation due to their unwillingness to participate in treatment programs against their will (Wilson, 1978), persons involved in programs operated by the probation agency have reduced recidivism for certain types of offenses (Gottfredson, et al., 1977).

Parole

Usually, parole is a term that describes both a release mechanism from incarceration and a form of community supervision. Consistent with this concept, parole is defined as “the conditional release of an inmate from incarceration under supervision after a portion of the prison sentence has been served” (Clear and Cole, 1990). Recent changes in sentencing toward determinate sentences and mandatory release has eliminated the discretionary power of parole boards, but has not superseded the need for community supervision of released felons.

Duties of the parole officer are virtually the same as those of the probation officer. Parole officers often act as intensive case managers, monitoring an individual's progress and helping to connect him or her to needed services in the community.

Communication and collaboration between correctional staff and community service providers is essential to help persons with mental illnesses function well in the community and successfully complete the terms of their probation or parole. Further, education of probation and parole officers in some of the unique problems that persons with mental illnesses face in the community can help the officers accommodate the sometimes unusual, but not criminal, behavior of those under their supervision.

Diversion to Community Services

Some individuals with mental illnesses do not belong in jail. In its 1988 report *Exemplary County Mental Health Programs*, the National Association of Counties noted “jail is inappropriate treatment for people with mental illness who commit misdemeanors or no crime at all. Such individuals need to be diverted from jail to a continuum of services which include crisis intervention, outreach, residential, vocational training, family support, case management, and other community support services” (Adams, 1988).

However, it is equally clear persons with mental illnesses who commit serious offenses “warrant correctional detention to accommodate criminal justice processing and community safety concerns” (Steadman, 1990). These individuals are not candidates for diversion, but require psychiatric attention. When individuals with mental illnesses can be appropriately diverted from the criminal justice system, it helps reduce jail overcrowding and promote the smooth operation of jail programs (National Association of Counties, 1988).

Individuals with mental illnesses may be identified for diversion from the criminal justice system at any point, including pre-booking interventions (before formal charges are brought) and post-booking interventions (after the individual has been arrested and jailed). Post-booking diversion efforts can take place in the jail or through the court system.

Regardless of its type or location, a diversion program is one that *screens* individuals for the presence of mental disorders, *evaluates* those persons determined to be in need of mental health treatment, and *negotiates* 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 (whether or not a formal conviction occurs).

This definition includes programs that allow individuals to await trial in the community, rather than jail. In addition, although it is not acknowledged as a formal diversion program, the plea bargain is often used to keep defendants with mental illnesses out of jail. Court decisions may range from dropping charges altogether to requiring mental health treatment as a condition of probation.

Diversion programs may be primarily operated by a mental health service provider or by a component of the criminal justice system, including the police department, jail, or courts. However, to be truly effective, diversion programs must involve the close collaboration of all relevant stakeholders. The benefits of such collaboration are substantial.

In addition to reducing the number of people held unnecessarily in jail, diversion programs help persons with mental illnesses become connected to appropriate community-based services, insuring continuity of care. This leads to minimum disruption in both the individual's life and the jail's programming and security. Another important benefit is that diversion programs can be developed without significant additional costs. The primary resources are spent in the development of working relationships among the key players, including police, courts, probation, jail staff, mental health programs, and other community resources.

Ultimately, for diversion to be successful, a wide array of community mental health and other support services must be available and accessible. Many individuals with mental illnesses have a range of needs, including medication management, housing, drug and alcohol abuse treatment, social services, and other supports.

Planning Cooperative Efforts

Coordinating the efforts of the mental health and criminal justice systems to meet the needs of persons with mental illnesses is critical to insure the proper functioning of the criminal justice system and to guarantee the provision of appropriate care for individuals with mental health needs. There are a number of barriers to this type of cooperation, however, including insufficient human and fiscal resources and a lack of understanding of the roles that personnel in each system can, and must, perform. Ways to overcome these barriers and implement joint programs that serve the needs of all involved are highlighted in Chapter Five.

CHAPTER 5

Solutions That Work

Barriers to Providing Care

There are numerous obstacles to providing appropriate care to persons with mental illnesses in the criminal justice system, including:

- lack of knowledge on the part of law enforcement and corrections personnel about effective mental health programs and how to access them;
- lack of understanding on the part of the mental health system about the demands and constraints of the criminal justice system and an unwillingness to work with its clients;
- lack of cross-training for corrections, law enforcement, and mental health staff; and
- lack of coordination between the criminal justice, mental health, and social service systems.

As was apparent in the vignettes in Chapter 1, inadequate or inappropriate information and fragmented services can result in persons with mental illnesses receiving no services at all, or receiving inappropriate treatment, including arrest and jail, because working alternatives do not exist in the community. Information sharing and coordinated planning among law enforcement and correctional personnel, mental health agencies, and social service providers — including housing, income support, and substance abuse programs — can help meet the needs of all parties involved.

This chapter highlights ways to coordinate care for persons with mental illnesses at key points in the criminal justice system, including examples of successful programs.

Core Planning Principles

Services for persons with mental illnesses who come into contact with the criminal justice system are critical and can be developed without substantial new funding. Much of what is required is rethinking how to address these problems. Comprehensive and integrated services at the client and system levels, with particular emphasis on community collaboration, are needed.

Many recent analyses of mental health services for underserved populations appropriately have emphasized the need for collaboration between private and public sectors and, in turn, among the local, State, and Federal levels of government. A major recommendation of the Federal Task Force on Homelessness and Severe Mental Illness stated, "There is growing consensus that a truly integrated system of care...requires integrating basic life supports with specialized services; linking services at the client and system levels; coordinating Federal, State, and local resources; and providing a clear delineation of authority and of clinical, fiscal, and administrative responsibility"(p. xiv).

At the heart of what needs to happen to significantly improve the lives of persons with mental illnesses who come into contact with the criminal justice system are several core planning principles. How each of these plays out in a specific jurisdiction for a particular set of problems will vary greatly. However, adherence to these principles will greatly increase the likelihood of solutions that benefit individuals, their families, criminal justice professionals and the community at large.

These core principles are:

- **Coordinated and integrated programs** clearly increase the likelihood of uninterrupted care, better psychiatric outcomes, and lower recidivism. Especially crucial in criminal justice contexts, fully integrated systems of care should include mental health, substance abuse and other health services, housing, assistance obtaining financial entitlements, and educational and vocational programs.
- **Access to targeted, appropriate and flexible** mental health services should be available to all persons with mental illnesses, regardless of whether these individuals are women, people of color, youth, or persons with special treatment needs.
- **Interagency working groups or planning teams** can greatly enhance the success of integrated services for persons with mental illnesses. These interagency working groups are important across all levels of government: Federal, State, and local. At the Federal level, this group would be able to target and coordinate efforts between all relevant departments to facilitate the improvement of mental health services to this population. At the local level, the group should have the authority to plan and implement a full array of integrated services.

- **Representatives from key constituencies**, including mental health administrators, criminal justice officials, substance abuse and other relevant service providers, and family and consumer advocates should be involved in the planning, implementation, and evaluation of mental health services for persons in contact with the criminal justice system.
- **Creative use of existing resources** can accomplish many of the needed changes to the criminal justice and mental health systems in the development of access to essential mental health services, without the need for a massive infusion of new resources.
- **Mental health services targeting the co-morbidity** of severe mental illnesses with alcohol and drug use disorders should be a priority. Mental health service provision, whether community-based or facility-based, should acknowledge the need to develop interventions and working relationships for persons with dual diagnoses.
- **Cross-training** of mental health, law enforcement and corrections personnel is crucial. Regardless of whether we discuss police, jails, prisons, or community supervision, the dominant theme is the need for both mental health and criminal justice personnel to better understand the demands, operations, and context of the other system.
- The identification of need and the provision of mental health services should **take cultural differences into account**. Because the persons involved with the U.S. criminal justice system, and, therefore, in mental health treatment services in these systems, are disproportionately African-American, Hispanic and other minorities, services should be provided that are culturally sensitive and that are geared to an individual's unique circumstances and needs.
- **The dissemination of existing knowledge and the generation of new information** to support the information needs of States and local communities could greatly improve services without substantially increased costs. This report has collected some of the best ideas available across the U.S. regarding the provision of mental health services to persons who come into contact with the criminal justice system. However, this information must first be available to communities if it is to have any effect. The establishment of a comprehensive information gathering and knowledge dissemination plan should be considered to provide the necessary information and technical assistance to implement or enhance services.

Effective Police/Mental Health Interactions

Effective police response to citizens with mental illnesses requires cooperation and the exchange of knowledge, resources and services between law enforcement, mental health, and social service agencies. Without such cooperation, police may resort to the inappropriate use of arrest or of emergency psychiatric hospitalization.

What officers most want and need in their interactions with persons suspected of having a mental disorder is information and access to consultation and assistance. There are a number of ways communities have met these needs, including the use of designated mental health professionals, special recognition for police officers handling mental health cases, emergency hotlines and 24-hour mobile crisis teams, cross-training of law enforcement and mental health personnel, and community planning. In all of these strategies, it is important to balance carefully citizens' rights to privacy with law enforcement officers' need for information. Each of these strategies is outlined below.

Designated Mental Health Personnel

Some police departments designate a mental health professional to handle cases involving persons with mental illnesses. Depending on the characteristics of the locality and the size of the department, this individual might be a police officer who is trained in mental health issues, a civilian mental health professional who works out of the police department, or a mental health professional from a community agency who contracts with the police department to provide crisis consultation and intervention.

These professionals are available 24 hours a day to respond to calls for assistance from officers in the field. They may offer advice over the telephone, go to the site to assist, or conduct evaluations in the office.

There are many advantages to all parties involved of having designated mental health personnel respond to persons with mental illnesses. These staff mean that police officers have a readily available source of expertise and someone who is responsible for screening, transportation, waiting for an evaluation, and follow-up.

Mental health agencies are more likely to receive appropriate referrals from such individuals, who can successfully negotiate for crisis intervention and other outpatient mental health services. And persons with mental illnesses are less likely to be arrested on minor charges or to be inappropriately hospitalized.

Recognition for Handling Mental Health Cases

Police interactions with persons with mental illnesses will be enhanced if officers believe that their role in determining the appropriate disposition is valued. This can involve notifying the officer of the results of a referral, allowing extra time for the disposition of such cases, and evaluating the management of a mental health case in much the same way as an arrest. Knowing that he or she will be rewarded for dealing effectively with persons with mental illnesses is an incentive for the frontline officer to make appropriate decisions regarding their treatment.

Emergency Hotlines and 24-Hour Mobile Crisis Teams

Many police encounters with persons with mental illnesses occur when mental health facilities are closed. The availability of mental health services after hours can be critical. Of particular importance are telephone consultation, on-site assistance in the form of mobile crisis intervention, and the availability for emergency hospitalization.

Some communities have found that emergency hotlines (both police and mental health) help solve problems that arise between the systems. Agreements of mutual support, often written and formal, mean that mental health professionals provide consultation and/or on-site handling of a difficult situation and police respond to a call for assistance when someone becomes violent in a mental health residence/facility (Finn and Sullivan, National Institute of Justice, 1987).

In addition, a special liaison (a management-level person from the police department and from the community mental health center) can help alleviate problems as they occur. The liaison has the authority to overcome staff resistance and program-level barriers.

Other communities have established 24-hour mobile crisis teams that can respond quickly to police calls for assistance. These teams take charge of the situation upon arrival (if the incident is not criminal), and screen, evaluate, and transport the individual to an appropriate treatment setting. Some communities have contracted with taxi services to transport individuals home, when this is an option. These simple solutions save an officer a substantial amount of time, allowing him or her to return to patrol work.

In addition, around-the-clock availability of hospital or community-based psychiatric evaluation, and specific guidelines for inpatient admissions, can help police officers make appropriate referrals. Cooperative agreements between police and screening facilities may be developed such that a psychiatric facility will identify available treatment slots elsewhere in the system if there is no space within that facility.

Cross-Training

Cross-training is probably the most important factor in cooperative working arrangements between the mental health and criminal justice systems. Police training generally focuses on characteristics and diagnostic issues related to mental illness, but has failed to address such issues as what services are available in the local area, how to make appropriate referrals, understanding confidentiality statutes and mental health law, and the goals and outcomes of treatment. Likewise, mental health professionals are rarely educated about the criminal justice system and the specific demands and procedures of police work.

In particular, it is essential that both police and mental health staff have a clear understanding about what information can be shared about individuals and of the rationale, both ethical and legal, for the policies. Access to information is a very sensitive matter that requires a careful balancing of individual rights to privacy with the community's right to protection.

Where police departments have a designated mental health unit, information maintained on contacts with persons with mental illnesses will be available to officers without involving a breach of confidentiality. If the department contracts for crisis intervention services, the crisis team may not be allowed to share confidential information with the police, but team members may use their knowledge to resolve a problem themselves or to suggest methods for resolution to the officer on site.

In addition to classroom or in-service training, cross-training may involve working in the environment, i.e., mental health workers riding in a patrol car, or police observing in a psychiatric facility.

Community Planning

People who come into contact with the police, particularly those with mental illnesses, have a high incidence of co-occurring substance abuse and physical health problems. In addition, they are likely to be poor and in need of housing or other social services. Helping individuals with multiple problems often requires systems-level integration, which ultimately supports and enhances the efforts of frontline law enforcement and mental health personnel.

At a minimum, communities may want to consider the development of a standing mental health/law enforcement planning committee, whose primary responsibility is to clarify the responsibilities of each of the agencies involved. Such a group should represent mental health clinicians and administrators, law enforcement and corrections officials, elected officials, and other relevant community service providers. The group may be supported by a formal memorandum of understanding and should have the authority to plan and implement a full array of integrated services to meet the needs of this population.

In particular, a joint planning group could develop streamlined procedures to facilitate appropriate inpatient and outpatient mental health treatment. In addition, such services as housing, alcohol and drug treatment, entitlement assistance, and education and vocational training programs should be available and accessible.

Making Maximum Use of Resources

These approaches to effective police/mental health collaboration usually can be accomplished with little or no additional funding. Making maximum use of existing resources, in some cases by jointly funding cooperative efforts, can resolve a majority of the issues presented herein. Some overtime pay for trainers and trainees, with occasional support for outside consultants, are often the only added costs.

Selection of Notable Programs

The Notable Programs included in this report were selected based on information from a number of sources. The selection of these programs represents the combined resources of the most current research, the opinions of program directors, and the expert advice of the 60-person Ad Hoc Working Group. Based on these experiences and information, programs were selected that were deemed especially noteworthy both because of the quality of what was being done and because of the transferability of their initiatives to other sites throughout the U.S.

Notable Program

Montgomery County, Pa., Emergency Service Program

The Montgomery County, Pennsylvania, Emergency Service (MCES) program was developed in 1974 as a response to the legal mandate to provide 24-hour emergency mental health care and to meet the need for readily accessible drug and alcohol emergency services, particularly for persons who come into contact with the criminal justice system. Through close cooperation with local law enforcement and jail, MCES provides a range of services, including inpatient treatment, training to police, crisis intervention with persons with mental illnesses in the community and mental health services to jail detainees.

Montgomery County Emergency Service is a nonprofit hospital. Its annual inpatient budget is approximately \$7 million. Inpatient services are paid primarily by Medicaid, Medicare, and third-party insurance. The hospital also receives direct funding from the county mental health department. In addition, approximately \$500,000 is budgeted for all other services and is paid for by county dollars, and services are billed to entitlement programs or private insurers as appropriate.

Police officers in Montgomery County receive training on how to identify and communicate with persons with mental illnesses who are experiencing crises. The officers carry a "cop card" with instructions for what to do when dealing with a person who has acute symptoms. In addition, police can telephone MCES at its 24-hour hot line to consult with a mental health professional. MCES may instruct the officer to bring the person in for evaluation or may send out an ambulance to pick up the individual.

MCES also operates a community outreach program in which crisis intervention professionals conduct a follow-up to further evaluate a situation that may be unresolved. Finally, for persons with mental illnesses already in jail, MCES has a forensic caseworker who develops treatment plans in the jail setting and provides linkage to services after release.

A major reason for the success of this program is its comprehensiveness. MCES provides access to inpatient care, follow-up services guaranteeing proper aftercare, emergency and crisis intervention services, in-jail services, and cross training of mental health, law enforcement, corrections and court personnel. Of primary importance is the Forensic Task Force. This group of individuals includes representatives from emergency, outpatient and inpatient mental health programs, police, jail, probation and parole, defenders and prosecutors offices, and consumer and family advocacy groups. The group has the authority to implement changes in the systems and function as a watchdog organization.

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Mental Health Interventions in Jails and Lockups

Individuals with mental illnesses present special problems to the jail administrator. Lack of knowledge about mental illnesses on the part of jail staff and other inmates means that persons with unusual behavior are treated either with fear or with punitive sanctions. Equally as problematic, persons with severe depression may go virtually unnoticed because they do not create disturbances. When this happens, they are left untreated and their symptoms may worsen.

Because jails have a constitutional duty to provide mental health treatment to individuals who require it, and a responsibility to provide a safe and secure environment for both staff and inmates, it is in the best interest of all concerned to stabilize persons who have mental illnesses. Effective mental health services can reduce security risks by helping persons with mental illnesses control their psychiatric symptoms and by educating staff to interact in a more positive way with these individuals.

Screening and evaluation are the first steps to identifying persons with mental illnesses who require intervention. This is the point at which individuals will either be diverted directly into mental health treatment (inpatient or outpatient) or identified for in-jail services. Thus, jails should have both pre-detention diversion options and provide or have access to a full range of mental health and discharge planning services.

Many experts stress the need to use community mental health resources, rather than developing mental health treatment programs in jails. The creation and support of a full array of in-jail mental health services not only duplicates what may be available in the community, but also might create an incentive for criminal justice personnel to incarcerate persons with mental illnesses as a treatment alternative (Steadman et al., 1989). The development of working agreements to purchase services from community mental health agencies and to transfer individuals to inpatient care when necessary is cost effective, allows for continuity of care, and supports development of the community service system.

Realistically, however, there will always be the need for a minimum number of services to be provided in jails, particularly where such services are not readily available in the local community. Among these services are inpatient beds either in jail or in a local hospital or psychiatric facility, around-the-clock mental health and nursing coverage, treatment planning, and the availability of psychotropic medications. In addition, opportunities for individual and group counseling and behavior management may prove useful.

Jails that do not provide a full range of services should, at a minimum, provide *screening and evaluation, crisis intervention and short-term treatment with the availability of psychotropic medications, and discharge/transfer planning.*

Screening and Evaluation

Screening involves continuing assessments of the mental health status, medication needs, and suicide risk of individuals being detained. It may be done formally by personnel trained in the identification of psychiatric problems using standardized instruments. More commonly, screening is accomplished informally by observation of an individual's behavior, appearance, and speech. Screening is the responsibility of all staff, including arresting and booking officers, supervisors, and other corrections personnel.

In lockups, the purpose of screening is to determine whether the person being detained is dangerous to him or herself or to others due to symptoms of mental illness or is so disabled as to require the immediate assistance of a mental health professional. Evaluations of this nature must be accomplished in a timely manner due to the acute nature of the problem.

Screening and evaluation in jails tends to be more complex and can be seen as a three-step process: routine mental health screening at intake, more in-depth mental health screening within the first 24 hours of admission, and follow-up mental health evaluation when deemed necessary.

Persons who are identified through these screening procedures as needing a full mental health evaluation should have one immediately in crisis situations or within 24 hours of a referral. Such evaluations will determine the level of each inmate's need for special housing and mental health treatment.

The critical importance of screening becomes apparent in the case of a suicidal inmate. Individuals in detention are nine times more likely than those in the general population to commit suicide, and most suicides occur in the first 24 hours after arrest (Jail Suicide Prevention Information Task Force, 1988). In 1986, 97 percent of persons who committed suicide in lockups and 89 percent of all suicide victims in jails had not been screened.

Persons who commit suicide while in detention are most likely to be male, white, arrested for a non-violent offense, and intoxicated at the time of incarceration (Jail Suicide Prevention Information Task Force, 1988). There is also some evidence linking the probability of suicide with the presence of severe mental disorders. While mental illness may increase the risk of suicide, screening and evaluation should be seen as a preventive measure for all persons detained in lockups and jails.

Crisis Intervention and Short-Term Treatment

Crisis intervention and short-term treatment are necessary in response to an acute, psychiatric condition that presents the possibility an individual will be of imminent danger to him or herself or to others. In lockups, crisis intervention may involve an immediate transfer of the individual to an appropriate mental health facility. Special precautions including close and continual observation until transfer are usually required during a crisis situation.

Crisis intervention in jails may involve the provision of more extensive services, including a brief mental health evaluation to identify the problem at hand, and emergency treatment where warranted. Such short-term treatment may include transfer to the in-jail inpatient or medical unit or to another inpatient facility, including State, county or general hospital settings. Other short-term treatment interventions include psychotropic medications, special observation, and some verbal therapies.

Effective crisis intervention and short-term treatment services require that staff are trained to recognize acute distress, that mental health professionals are accessible on a 24-hour basis to assist with evaluations, medications, and emergency placements in community facilities, and that special housing units are available for inmates who require close observation or extra medical supervision in jail. Formal and informal working agreements between jails and community mental health providers insure that individuals in crisis receive appropriate care and jail operations are not disrupted.

Discharge/Transfer Planning

Discharge or transfer planning helps individuals being released to the community or being sent to prison connect with appropriate mental health services. In a recent study of all U.S. jails, only 26 percent reported offering discharge planning services (Morris et al., 1994).

Discharge planning in lockups is generally restricted to communicating with the appropriate receiving facility, including the court and jail, to insure continuity of care. As part of a jail mental health program, discharge planning is usually the responsibility of a case manager who is a mental health professional.

Typically, this individual makes referrals or appointments with mental health agencies for continuing mental health treatment after release, and notifies State prison officials for those being transferred. In addition, case managers can facilitate an individual's release by helping with arrangements for housing, social services, and other supports. Medication management and independent living skills training may be especially important.

Principles for effective discharge planning include the following (Griffin, 1990):

- **Discharge planning must be a clearly articulated goal of the jail mental health program.** Making it a priority helps to justify the allocation of resources toward this important task.
- **Close collaboration between the criminal justice and mental health systems is essential.** Whether the relationships are formal or informal, it is important that all key players participate to insure comprehensive and continuous services to persons with mental illnesses preparing for release.
- **Discharge planning must begin in advance of release from jail.** Because individuals typically spend a very short time in jail, such efforts should be integrated into the ongoing evaluation and treatment process.
- **Continuity of care should be insured** by determining that all individuals leaving jail have referrals for aftercare and that they are encouraged to participate in mental health services. Case managers may need to facilitate such ongoing care by working directly with individuals and by expanding their network of community resources.

Notable Program

Summit County, Ohio, Jail ADAPT Program

The Summit County Jail Unit in Akron, Ohio, was renamed the Alcohol, Drug Abuse and Psychotherapy Team (ADAPT) in 1992. Its primary responsibilities are: psychosocial assessments, crisis intervention, management of acute psychotic episodes, monitoring of detoxification, suicide prevention, prevention of psychological deterioration while incarcerated, chemical dependency treatment, education focused on individual needs, elective therapy services including individual and group, and, administrative assessment and planning for continuing services. These services are available to all inmates of the Summit County Jail (rated capacity 402) at no cost to the individual inmate. Referrals are made to community agencies for follow-up services.

In addition to the use of traditional mental health providers, the Summit County Jail created a Crisis Intervention Specialist position to address the critical need to respond to crises quickly and professionally. This staff member enables the jail to speed up the classification process for persons with mental illnesses and to more effectively bring individuals' mental health needs to the attention of mental health staff.

Inmates who are at high risk may be housed in the mental health housing units where they are more closely observed and monitored by professional ADAPT staff and deputies. These inmates may include those who are actively psychotic, suicidal, or in withdrawal. Corrections staff for the mental health unit are selected jointly by the ADAPT director and correctional security supervisors. These deputies work only on the mental health unit.

Jail mental health services are enhanced by the use of a computerized information tracking system. This system is used to track all inmates who have received a mental health evaluation. The information contained in the system includes demographics, diagnosis, staff time, and the number of inmates using each type of service.

Training for staff of the Summit County Jail is also provided and includes such topics as: recognition of signs and symptoms of intoxication, withdrawal and mental illness, suicide prevention, crisis intervention, and stress management.

ADAPT does not provide follow-up services in the community, feeling that the community resources are appropriate for such services. They do provide referral to community resources in attempts to provide for continuity of care.

The Summit County jail employs a unique blending of resources to fund its mental health services staff. Self-employed contractors make up the bulk of this staff. Actively seeking grants to supplement the county's budget has enabled the mental health coordinator to retain additional mental health personnel. Currently there are two funding streams through mental health services are provided: positions for the jail staff are financed by the county, while the self-employed contractors are compensated with resources obtained from various grants.

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Mental Health Interventions in Prisons

Consistent with the concept of a “community mental health system,” prisons should provide a full array of mental health services, beginning with screening and evaluation and crisis intervention at the “front door,” through psychotropic medication and monitoring, individual and group therapy, case management, and specialized housing in prison, to discharge planning and referral at the “back door.” In non-prison communities, the use of outpatient services can significantly enhance an individual’s ability to live and function in the community; thus, with similar help, inmates with mental illnesses can learn to function in the prison general population.

Lack of financial resources and prison overcrowding have created significant barriers to the provision of quality mental health services in prisons. In addition, mental health services can be provided under different auspices, typically by the State department of mental health or the State department of corrections. In some States, mental health budgets are being drastically reduced and corrections budgets are continuing to expand. Clearly, each State will differ in its resource allocation and must decide independently on the best way to support prison mental health services, both fiscally and administratively (Cohen and Dvoskin, 1992).

The information in the following sections draws heavily from the work of the National Coalition for the Mentally Ill in the Criminal Justice System. The group’s recent monograph, *Mental Illness in America’s Prisons*, represents current thinking about how to design and deliver mental health services to prison inmates.

Screening and Evaluation

One of the major reasons why prison inmates with mental illnesses do not receive services is that they are inadequately screened. Ogloff and colleagues (1993) recommend that screening be a two-stage process: a brief mental health screening for every inmate upon admission to the prison, and a more in-depth mental health assessment for those who are identified during the screening process as needing further evaluation.

These early assessments help prison staff: (1) identify inmates who are at risk of injuring themselves or others; (2) determine whether an inmate is so disabled that he or she cannot function in the general population; (3) assess the need to transfer the inmate to a mental health facility outside the prison; and (4) decide whether the inmate will benefit from mental health services.

American Psychiatric Association standards suggest that a mental health professional or trained corrections officer screen all inmates immediately on admission to the prison, using a standardized set of instruments with a low-threshold designed to detect any evidence of mental health problems. Further screening should be part of a standard medical workup conducted by health care personnel. Records accompanying an inmate may be inadequate, making careful assessments particularly important. When they are screened, inmates should be provided with information about mental health services available in the prison.

In addition to the formal screening procedures, corrections and mental health staff must continuously observe inmates for changes in behavior that might indicate a worsening mental health condition. Some inmates may develop mental health problems while in prison, and the mental health status of others may change during the time they are incarcerated. Although corrections officers are likely to be the ones who have the most day-to-day contact with inmates, additional personnel, including teachers, librarians, nurses, and other support staff, should be trained to recognize mental health problems (Ogloff, et al., 1993).

This training should include recognition of so-called positive symptoms, such as hallucinations or delusions, and of negative symptoms, including withdrawal. Often, non-disruptive inmates do not come to the attention of the mental health staff even though they may be in acute need of services.

Clearly, diagnosis of mental health problems is an important feature of screening and evaluation. However, as Ogloff and colleagues (1993) caution, diagnosis is not equivalent to impaired functioning. "Very often mentally ill inmates are not disruptive and will not harm themselves, while many disruptive inmates are not mentally ill. Therefore, rather than just focusing on identifying mental illness, it is important to consider inmates' psychosocial functioning." Given the stigma associated with mental illness, it may not benefit an inmate to be designated mentally ill if he or she can function well within the prison community and/or if there are no appropriate mental health services or programs available to meet his or her specific needs.

Crisis Services

Regardless of the effectiveness and thoroughness of the screening process, mental health crises can occur at any time. Crisis services must be available to all inmates on a 24-hour basis; a timely response is critical to stabilize the inmate and prevent further disruption to the individual and to the prison. Effective crisis intervention programs should include steps to reduce the probability that a crisis will recur (Cohen and Dvoskin, 1992).

Crisis services generally involve a mental health evaluation to determine the nature of the problem, followed by emergency treatment. Such treatment may include transfer to inpatient treatment (either within the prison or outside) or to special medical/psychiatric housing units, the use of emergency psychotropic medications, and the use of special observation. Emergency treatment services generally will not exceed 72 hours, after which the services the inmate receives become part of his or her on-going treatment plan.

For these services to be effective, all corrections staff must be trained to recognize when an inmate is in crisis. It is important to underscore that attention must be given to both the "positive" and "negative" signs of mental illness, that is, withdrawal and loss of appetite should be given as high a priority as hallucinations and delusions. In addition, mental health and medical personnel must be available on a 24-hour basis.

When a crisis occurs it may be necessary to remove the inmate from the general population. Inpatient hospitalization can often be avoided through the use of short-term crisis beds within the prison setting (Cohen and Dvoskin, 1992).

Mental Health Treatment Services

One of the primary issues in reviewing mental health treatment for prisoners has typically been the lack of discussion regarding what types of services and modalities are effective. Certainly, there is support for the effectiveness of psychotropic medication. However, medication does not work for all people and, given the sometimes severe side-effects, may be refused. Nor would mental health professionals generally recommend medication alone as an appropriate intervention.

Thus, mental health services in prison must include a wide array of approaches. Rice and Harris (1993) cite support for the use of behavioral interventions with this population. They suggest a two-pronged approach designed to reinforce appropriate behaviors and to address specific deficits with skills training. Such techniques have been used successfully in Canadian prisons.

Assertive outreach and case management are key components of effective mental health services within the prison setting (Cohen and Dvoskin, 1992). This is especially true for groups with special needs, such as combat veterans, adult survivors of childhood physical or sexual abuse, victims of physical or sexual assault in prison, or inmates housed for long periods in disciplinary segregation.

Special Housing

To meet the needs of inmates with mental illnesses over long periods of time, a continuum of housing options must be available within the prison setting. In addition to crisis beds and access to inpatient treatment, long term residential treatment units (RTUs) complement the needs of inmates with mental illnesses.

Inmates with severe mental illnesses often have trouble dealing with the stresses of prison life and are particularly vulnerable to abuse from staff and other inmates. RTUs, which feature separate housing and therapeutic interventions, can dramatically improve an inmate's quality of life while providing a safer environment. These services can be transitional in nature or be a permanent housing option for those who need it.

Specialized residential units do not necessarily require 24-hour a day medical coverage and can be a cost-effective alternative to psychiatric inpatient treatment without compromising the inmate's mental health care. In a study of New York State prisons, Condelli and colleagues (in press) found that such programs reduce psychiatric crises, disciplinary violations, suicide attempts, and hospital transfers.

Inpatient Services

Psychiatric inpatient services are a necessary component in the continuum of care, but are not required to be operated by the prison. If the other aspects of the continuum of care noted herein are present, the number of inpatient stays can be minimal and the average length of stay typically short (under 60 days).

If the prison or prison system does have a psychiatric inpatient facility, these units may want to seek accreditation by the Joint Commission on the Accreditation of Health Care Organizations (JCAHO). While there is no mandate for prison psychiatric inpatient facilities to be accredited, such accreditation of civil facilities presumes a minimum of constitutionally adequate care (*Woe v. Cuomo*).

Discharge Planning and Referral

Discharge planning helps insure continuity of care for inmates, but this is more complicated in the prison setting than in jails because prisons are not typically located in the communities to which inmates are released. Formal or informal linkages between State facilities and local providers are seldom developed.

Typically, transfers to other State prisons or to psychiatric facilities are relatively easy to facilitate. But there is often little that a discharge case manager can do to guarantee that someone released upon completion of a sentence will receive needed mental health services in his or her own community. Resource development is needed to enhance the connections between the criminal justice and mental health systems at the State and local levels.

A strong working relationship between prison-based counselors and State parole agencies can be an important indirect mechanism for insuring continuity of care for persons released on parole. Parole supervision can require participation in mental health treatment programs. While parole boards are often reluctant to release inmates receiving mental health treatment, it is likely that more such individuals would be released to their communities if formal agreements for their care and supervision were developed among prison administrators, parole officers, and local mental health providers.

Specific policies and procedures governing the method of transfer, the exchange of medical records and information, and the means of notifying the receiving facility or agency should be developed at each institution. In addition, there should be a designated mental health professional whose responsibility it is to plan for inmate transfer or discharge.

Notable Program

New York State Prison Mental Health Program

New York State provides mental health services to individuals who have been sentenced through one psychiatric center and 11 satellite units throughout the State prison system. The Central New York Psychiatric Center, a 191-bed hospital that operates under the auspices of the New York State Office of Mental Health (OMH), is a fully-accredited psychiatric inpatient facility. Although its perimeter security and procedures are as stringent as any maximum security prison, within that perimeter the facility functions as a psychiatric hospital with a wide range of environments offering various levels of unrestricted movement.

The satellite units provide a range of services to each prison cluster. These include screening and referral; crisis beds, with an average stay of less than 10 days; long-term residential treatment units called intermediate care programs; outpatient treatment, which usually includes medication and/or psychotherapy, for those living in the general population; and pre-discharge planning services for inmates about to be released or paroled.

Screening and Referral

At New York's reception corrections facilities, satellite units focus on screening and follow-up evaluations of incoming inmates to determine those who are likely to have a high level of need for mental health services during their incarceration.

After inmates are screened a follow-up review is conducted to discuss whether the inmate needs or wants services and the proposed requirements. Each inmate is given a mental health service designation, which determines to what institution an inmate is transferred, so that at any given time those inmates most likely to need intensive services will be housed in institutions with satellite units.

Crisis Beds

Each satellite unit has a crisis bed capacity of approximately 10 beds. These are for short-term placements that allow inmates to receive treatment aimed at stabilizing crises such as acute psychoses or suicide attempts. Treatment includes medications and verbal crisis-oriented therapy.

Intermediate Care Programs (Residential Care)

For some inmates, the general prison population can be so stressful that they are in a constant state of crisis. New York realizes that this group needs a level of service less intensive than crisis beds or inpatient hospital care, but more intensive and supportive than general population outpatient care. The intermediate care programs were created to meet this need.

Outpatient Services

Each satellite unit maintains an outpatient caseload of general population inmates who receive regular treatment, most often medication and/or psychotherapy. This level of treatment is meant to help the inmate live and work within the general prison community. Satellite unit staff provide consultation on all aspects of the prison program and security operations to help maintain a safe and secure environment for all staff and inmates.

Pre-Discharge Planning Services

Several years ago, OMH determined that the weakest part of the service delivery system was the pre-discharge planning services for those inmates preparing for release or parole. Each satellite unit now has a discharge coordinator who works closely with the Division of Parole and the State and local mental health service network. Current initiatives include negotiations to develop a process of Medicaid review to enable newly discharged parolees to avoid long delays in receiving needed mental health services in the community; and an Intensive Case Managers program devoted exclusively to parolees with mental illness.

This program is expected to reduce the reliance on crisis-oriented care and is designed to tailor services to the client. Specially trained parole officers will be assigned to work as a team with several intensive case managers, with progressive sanctions aimed at reducing technical violations by giving parole officers more choices (as opposed to revocation) for responding to episodes of treatment failure.

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Mental Health Interventions for Persons on Probation and Parole

The first months are a critical period in the transition of an individual from jail or prison to community living. For persons with mental illnesses, entitlement benefits and stable housing are important components to success. However, these may be especially problematic for newly released parolees.

Prior to 1985, prison inmates were eligible for Medicaid coverage during their first and last months of incarceration. Currently, prison inmates are not eligible to receive Federal entitlements — including Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), or Medicaid — while they are in prison. The earlier practice both allowed for diversion of mentally ill individuals into treatment programs and facilitated the referral of clients to services after release. Medicaid can be as an incentive to providers to accept difficult clients that they would otherwise reject.

Another difficulty facing these individuals and their probation/parole officers is the reluctance of many mental health services agencies to provide treatment to persons with a criminal record or to those individuals who are participating in services involuntarily. At the same time, probation and parole officers may find it difficult to help persons with mental illnesses complete their sentences if they are unaware of the behavioral and social problems these individuals may experience as part of their disorders.

Clearly, the most important component of effective mental health service provision to persons on probation or parole is close collaboration between probation/parole officers and community mental health providers. Cross-training of staff may be critical to the success of these collaborative efforts.

Accessing Community Treatment

Individuals with mental illnesses on probation and parole, like other community members with similar problems, require the availability of a full range of mental health services that are accessible, appropriate, and relevant to their needs. Mental health treatment may be a condition of probation or parole for some individuals; for others, participation in such services is voluntary.

Some probation and parole agencies have developed standing contracts with community providers. These working agreements support the activities of both systems and the clients they jointly serve. Community agencies that work with individuals on probation and parole tend to be familiar with corrections practices and are more receptive to nonvoluntary clients (Cole, et al., in press). Such arrangements may also allow for parole/probation officers to intervene in emergencies that involve persons under supervision at the mental health service provider site.

In addition, probation and parole officers may take advantage of mental health intensive case management programs, where they exist. These programs typically provide support for many domains of living, including housing, mental health and other support services, and finances. The intensity of the services and the funding is flexible. Such programs appear to be effective in reducing the inappropriate use of psychiatric services and the number of days spent in hospitals and jails by some of the most difficult-to-serve individuals.

While such arrangements insure access to treatment for many individuals with mental illnesses, problems may arise when the mental health agency is not equipped to serve persons with varying levels of disability, or with differing needs and interests. In addition, the high co-occurrence of substance use disorders in this population may require the involvement of other service providers. Interagency collaboration among key organizations is required to make these efforts work. Community planning committees that involve probation and parole staff, substance abuse and mental health providers, housing programs, and local social services agencies can develop a network of flexible services. Formal agreements and memoranda of understanding may insure access to treatment for persons with mental illnesses on probation or parole.

Information exchange and mutual support between participating agencies is critical. In particular, issues of client confidentiality must be explored. While community supervision officers must be informed of an individual's non-participation in services when treatment is a condition of release, many mental health consumers object to the idea of complete information exchange between the mental health and criminal justice systems. Discussions with consumer advocacy groups may allow a clearer understanding of the kinds of circumstances under which information may be exchanged.

Staff Training

Staff training is a key component at all levels of criminal justice/mental health interactions. For effective community supervision of persons with mental illnesses, probation and parole staff and mental health providers must understand each others' roles. In particular, community supervision staff need to understand the effects of mental illnesses on daily functioning.

Probation and parole officers may have internal conflicts between their roles as facilitators/helpers for persons under their care and as enforcers of probation and parole sentences. "Odd behavior by clients may be interpreted from an organizational viewpoint that emphasizes client compliance, rather than a clinical standpoint that seeks to interpret behavior in terms of a need for intervention. This could result in higher revocation rates for mentally ill offenders, based not only on the offenders' behavior, but also on the inadequate training of parole staff" (Clear, et al., in press).

To increase the likelihood of success for persons with mental illnesses, all community supervision staff should be trained to identify the symptoms of mental illnesses, to understand some of the unique problems and issues facing persons with mental illnesses in the community, and to accommodate the sometimes unusual, but not criminal, behavior of those under their supervision. By the same token, community mental health providers need to be informed about the demands and nature of the criminal justice system and the need to work with persons who have mental illnesses to help them meet the conditions of their probation and parole.

Special Accommodations for Persons with Mental Illnesses

Persons with mental illnesses tend to have high rates of technical violations of their probation and parole sentences. To accommodate their unique needs, many community supervision departments have developed some specialized services to help persons with mental illnesses become successfully integrated into the community and meet their conditions of release.

Technical violations of the conditions of release tend to be all or nothing decisions. Alternative strategies allow for continuous monitoring, increased communication between community supervision and other provider agencies, greater client responsibility, and sanctions that allow for some mistakes without resulting in an immediate return to jail or prison.

Specialized Caseloads

Persons with mental illnesses on probation or parole may be assigned to a specialized community supervision caseload. Such specialized caseloads tend to be smaller, and the probation/parole officer in charge of these clients has special skills and knowledge that may facilitate the integration of the individual with mental illness into the community.

Sometimes these services are transitional. Persons with mental illnesses who are newly released from jail or prison may be assigned to a specialized caseload. Because these individuals may have more difficulty adjusting to community living after incarceration, have fewer natural resources (e.g., employment, social supports, housing), and require supervision of special conditions for treatment, such early, intensive supervision tailored to the specific needs of each person can be important. Once the individual is stabilized in the community, he or she may be transferred to a generic caseload.

In addition, persons with mental illnesses may require more intensive supervision at a later date. It is important that probation and parole departments be able to monitor and reassign individuals based on current need.

Relapse Prevention

Relapse prevention is a recent model that has gained wide support (Palmer, 1992). This approach focuses on the development of social and emotional supports that reinforce an individual's resistance to further criminal behavior.

The key to this effort is the probation/parole officer who acts as an intensive case manager, maintaining up-to-date information on the individual's progress in treatment programs and in employment, family, and social environments. Effective monitoring allows the officer to anticipate periods of increased stress, exacerbation of symptoms, and possible criminal activity and to intervene to avoid recidivism. This approach incorporates and articulates the shared responsibilities of the client, community supervision staff, and service providers in the overall outcomes.

Progressive Sanctions

Progressive sanctions for technical violations is another strategy that may be used alone or in conjunction with other models to reduce recidivism for persons with mental illnesses. This approach recognizes the fact that many persons with mental illnesses on probation and parole are in a “catch-22” situation.

Terms of probation and parole often mandate mental health treatment for individuals with mental illnesses, and a client’s refusal to cooperate with the treatment plan may result in an increased number of technical violations (Clear and O’Leary, 1983). The purpose, however, of mental health treatment in this context is to increase the probability of successful completion of probation/parole. Thus, if community supervision staff adhere to strict sanctions for technical violations in regard to treatment compliance, special needs clients, particularly those with mental illnesses, are likely to fail.

To avoid this problem, the use of progressive sanctions is suggested. The essential component of this effort is to avoid an “all or nothing” approach to success or failure in treatment. For example, as described by Clear and colleagues (in press), “clients might initially be required to check in with their parole officer weekly, but after failing to show up for several psychiatric clinic appointments, the parole officer might increase the frequency to several times per week. It is the nature of serious mental illness to have periodic exacerbations and remissions, and progressive sanctions allow the system to provide responsive increases in structure without necessarily returning the person to prison.”

For this strategy to be effective, open lines of communication and cooperation must be maintained between probation/parole departments and community mental health and other service providers.

Notable Program

Oregon Special Needs Release Planning Program

In June 1992, collaboration between the Health Services Division and Release Services produced a pilot program to improve release planning for long-stay inmates with mental health or medical problems who are returning to the community. Previously, planning release for persons with mental illnesses or medical problems had been a complex, time-consuming and frustrating task because of their complex needs and the lack of appropriate resources in many communities.

To reduce the problems associated with release to the community, Oregon developed the Special Needs Release Planning program, funded entirely by the Oregon Department of Corrections. Up to six months prior to his or her release date, a packet of information, including criminal history and psychiatric evaluations, is sent to the county mental health and county parole and probation offices. These offices send staff to evaluate the inmate and, then work together to develop a community plan, including linkage to mental health services with medication monitoring and the establishment of needed supports, including housing and entitlement benefits (particularly a Medicaid card).

In addition, parolees with mental illnesses who are returned to prison on technical violations are intercepted and sent directly to the Special Management Unit where their symptoms are stabilized. This shortens the process, and inmates are usually returned to the community in 60 to 90 days.

This initiative has developed referral agreements and protocols with many service provider agencies, streamlined application procedures for Social Security Administration benefits, established working agreements with four county community mental health agencies, and developed a procedure to enable civil commitment of severely mentally ill inmates to State psychiatric centers. In addition, the team approach between community mental health and probation/parole encourages cooperation and reduces the probability that a newly released inmate will fall through the cracks. In view of the success of the program, parole boards are increasingly referring inmates that could benefit from these special services.

In its first 18 months of operation, the Special Needs Release Planning Program has served approximately 150 persons, two-thirds of whom had diagnoses of severe mental illnesses. Of these, 80 continue to be monitored in the community by the program.

This project has succeeded in establishing a single point of referral for release planning for complex cases, has leveraged resources that had not been available to this population previously, has impacted public safety and saved cost associated with recidivism, and has benefited clients who require assistance to return to the community safely.

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Diversion to Mental Health Programs in the Community

The most effective types of jail mental health diversion do not end when the detainee leaves the jail. In order for jail and court diversion programs to be successful, they must be part of a comprehensive array of other jail services including screening, evaluation, short-term treatment, and discharge planning (i.e. linkage) that are integrated with community-based mental health, substance abuse, housing, and social services.

The best diversion programs do not simply look to keep persons with mental illnesses out of jail. They see them as citizens of the community who require a broad array of community-based services. They recognize that due to the nature of mental illnesses—and without the assistance to overcome the barriers created by fragmented services and the lack of social supports and other resources—these individuals may return to jail.

As previously noted, jail diversion programs can be divided into pre-booking and post-booking interventions. Pre-booking diversion occurs at the point of contact with law enforcement officers. If this is done effectively, as described earlier in this chapter in the section “Effective Police/Mental Health Interactions,” persons with serious mental illnesses will be diverted prior to arrest.

Effective strategies for post-booking diversion differ from those prior to arrest. Based on information recently gathered as part of a National Institute of Mental Health-funded study (Steadman and Morris, submitted), the following six factors represent the key components associated with effective court- and jail-based diversion programs:

- services integrated at the community level with corrections, mental health, the judiciary, and social services such as housing and entitlements;
- regular meetings of key agency representatives to encourage coordination of services and sharing of information;
- liaisons to manage the interactions between the correctional, mental health, and judicial systems;
- a strong leader with communication skills and an understanding of all of the system components and the informal networks;
- early identification of detainees with mental health treatment needs who meet the diversion program’s criteria; and
- nontraditional case management services, involving case managers who are familiar with both the criminal justice and mental health systems and who are culturally and racially similar to the clients they serve.

Notable Program

Honolulu Jail Diversion Program

The Honolulu Jail Diversion program is a court-based program that transfers misdemeanants with mental illnesses from the jail into mental health treatment. The Jail Diversion Program was begun in 1988 with Robert Wood Johnson Foundation funds. Since July 1991, the program's funding has come from the State's general fund, administered by Adult Mental Health Services, Department of Health.

Potential participants are identified through the following procedure. During the prearrestment interview, non-mental health staff screen all detainees and flag those who appear to have acute mental illnesses. Arrestees are moved at 6 a.m. every morning from the Honolulu Police Department to the Arraignment Court. Diversion staff interview the identified detainees to determine whether they are appropriate for diversion.

The program is entirely voluntary. Individuals who choose to participate in the program are asked to sign a release of information form allowing program staff access to their medical and mental health records. By the time of arraignment at 8:30 a.m., the Diversion Program's Case Coordinator has arranged for mental health services and negotiated the acceptance of the diversion plan with the district attorney's office, the public defender, and the judge.

If the detainee agrees to participate in the recommended mental health services, he or she is released on his or her own recognizance by the Arraignment Court after a court date is set. The Jail Diversion program staff arrange for a same day appointment at the CMHC, VA outpatient clinic, or other appropriate community-based mental health program. Program staff drive the client to the appointment and wait while the client is seen.

Much of the success of the program is due to the program's ability to respond quickly, to arrange referrals and to the availability of the Case Coordinator to transport and wait for clients to be seen. In addition, extensive follow-up help to assure a successful outcome. Clients are called every 60 days at a minimum to find out how they are doing, whether they are still participating in services, and whether further assistance is needed.

Court dockets provided by the judiciary are reviewed each day for the next day's cases. Any Jail Diversion program client scheduled to appear is called, and if he or she needs help getting to court, the Case Coordinator will provide transportation. Case Coordinators accompany all clients to trial court.

The Jail Diversion program maintains client charts on all participants. If service providers lose contact with a client, this file can be used to help locate and reconnect the person to services.

This program diverts misdemeanants from jail while awaiting trial, substantially reducing the time an individual will spend incarcerated regardless of the outcome of the trial. Using assertive case management, the probability that clients will miss court dates (avoiding bench warrants) and drop out of treatment is also decreased.

The keys to the success of this program are: (1) the presence of an effective leader who is familiar with corrections, the courts and the mental health system in Honolulu; (2) information sharing between mental health and the jail diversion program; (3) aggressive case management with same day mental health clinic visits and real access to services; and (4) multicultural staff who work well with the clients in the program.

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