



# **Criminal Justice Primer for State Mental Health Agencies**

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# Message from the Little Hoover Commission

*State of California*



## LITTLE HOOVER COMMISSION

July 2002

Dear Friends:

Michael E. Alpert  
*Chairman*

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Policy-makers and the public have become increasingly concerned with the plight of people with unmet mental health needs. The U.S. Surgeon General's historic report on mental health and the establishment of the President's New Freedom Commission on Mental Health have bolstered the momentum of reform efforts.

While this national leadership is essential to reforming mental health policy, the performance of public efforts is ultimately the result of state and local initiative. That is why I am honored to introduce this report on the relationship between the mental health and criminal justice systems. California's Little Hoover Commission has partnered with the National Association of State Mental Health Program Directors on this project as a way to challenge and guide local leaders to champion reform in their own communities.


Throughout the nation, billions of dollars are spent responding to the consequences of untreated mental illness—rather than efficiently and effectively addressing those needs. We pay for jails, prisons and court costs because mental health treatment is not available.

In California, the Commission concluded that we have criminalized mental illness. State and federal statutes instruct service providers to turn away those in need because funding is limited. But law enforcement is expected to respond to every call, to keep every peace, and to ensure everyone's safety. Absent adequate mental health services, the cop has become the clinician. The jail has become the crisis center. As this report explains, other states face similar realities.

This primer outlines the opportunities and the benefits of tailored services, enhanced cooperation among public agencies, and continuous improvement of services. It also describes efforts already underway around the country to improve outcomes. These efforts demonstrate that improving mental health care yields positive returns including lower criminal justice costs, healthy business districts, and more importantly - a renewed hope for people who are too often viewed as a liability rather than an asset.

Sound mental health policy is about compassion for human suffering and the quality of life in our communities, our neighborhoods and in our homes. I urge you to review this report, to become aware of innovations taking hold around the country and to do your part to ensure that no one ends up in the criminal justice system because appropriate mental health care was not available.

Sincerely,

  
Michael E. Alpert, Chairman

The Little Hoover Commission is an independent state oversight agency in California. The bipartisan Commission is composed of five public members appointed by the Governor, four public members appointed by the Legislature, two Senators and two Assemblymembers. Copies of the Commission's reports on mental health are available on its Web site at [www.lhc.ca.gov/lhc.htm](http://www.lhc.ca.gov/lhc.htm).

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## Introduction

The purpose of this document is to offer decision makers and their staffs a basic understanding of the growing overlap between the criminal justice and mental health systems. The number of people with serious mental illness who are involved in the criminal justice system has grown considerably in recent years and shows no signs of abating. Resolving the problem will require a level of coordination rarely seen between the two systems, which traditionally have had divergent missions and cultures. The mental health system is designed to provide treatment while the criminal justice system functions to protect the public. When a mental health system is unable, for whatever reason, to provide the treatment and supports necessary for an individual to function within the community, the involvement of law enforcement increases.

The influx of persons with a mental illness into the criminal justice systems is the result of a web of interrelated causes:

- ◆ the downsizing of state psychiatric institutions;
- ◆ inadequate community-based mental health services;
- ◆ the economic pressures imposed upon treatment systems by managed care;
- ◆ punitive laws that tend to penalize people with serious mental illness;
- ◆ a lack of pre-arrest intervention services; and
- ◆ a lack of appropriate services designed to reintegrate a person with serious mental illness into the community following release from jail or prison.

These policy failures result in what some refer to as the criminalization of mental illness: Because of inadequate services, a growing number of persons with serious mental illness are being treated as criminals. As awareness of this trend increases, a consensus among policy makers is emerging that criminalization is morally bankrupt, ineffective, and a poor use of public resources. The solution begins with greater coordination between mental health and criminal justice systems. This primer defines the dynamics of this problem and offers some potential responses for arriving at a solution.

The field of mental health owes a tremendous debt to the Little Hoover Commission's 2000 report, *Being There: Making a Commitment to Mental Health*. The report's chapters, "Decriminalizing Mental Illness" and "Coordinating Mental Health and Criminal Justice Services," are at the core of this primer. While the report's discussion focused on California, many of its findings and observations are applicable to mental health systems across the country.

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## **A Problem with Many Causes**

Since the 1960s, when states first began closing and consolidating their psychiatric hospitals, the number of persons with serious mental illness involved in the criminal justice system has grown considerably. Comprehensive community-based services were intended to serve individuals who were previously hospitalized, but funding and other barriers have stunted the development of these comprehensive systems. Consequently, many people with serious mental illness have become trapped in the revolving door of crisis hospitalization, homelessness, and arrest. The Los Angeles County Jail is now considered the nation's largest psychiatric institution. New York City's jail at Rikers Island isn't far behind. However, the problem is not unique to major urban areas.

According to the U.S. Department of Justice, which released a report that assessed the need for mental health services in correctional facilities, by mid-1998 more than a quarter million people with mental illness were housed in the nation's jails and prisons. An additional 548,000 persons with mental illness were on probation. The study found that nearly a third of state prisoners (30.2%) had received mental health services at some time. More than half of that group (16.2% of all state prisoners) either reported a current mental condition or had been hospitalized overnight for a mental or emotional problem (U.S. Department of Justice, 1999).

Persons with serious mental illness are over-represented throughout the criminal justice system. They are incarcerated for longer periods of time and have higher rates of recidivism. The average time served for prison inmates with mental illness is 103 months (8.6 years), versus 88 months (7.3 years) for other prisoners. Among repeat offenders, 53% of state prisoners with mental illness had a current or past sentence for a violent offense, compared with 45% of other inmates (U.S. Department of Justice, 1999). Furthermore, the stressful environment found in jails and prisons exacerbates existing symptoms and can bring out additional symptoms in inmates who are prone to mental illness.

The majority of persons with serious mental illness in state prisons and local jails are thought to be non-violent, low-level offenders. Harsher drug laws and a lack of affordable housing are factors that make it more likely that persons with mental illness get involved with the criminal justice system (U.S. Department of Justice, 2001). The situation raises a major dilemma for state and local officials about how the mental health system can respond most effectively to the criminalization of persons with serious mental illness. The solution requires active coordination between mental health and criminal justice systems.

## **Law Enforcement "Safety Net"**

The Justice Department's report confirmed stakeholders' concerns that in the absence of comprehensive community-based systems, prisons and jails have become the nation's default institutions for people with serious mental illness. Inadequate mental health systems have led to the criminalization of behaviors associated with mental illness. In the absence of other support services, the criminal justice system becomes the only resource available to persons with mental illness and their families in times of crisis. Law

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enforcement has become the nation's mental health safety net (Little Hoover Commission, 2000).

While psychiatric facilities offer around-the-clock care to people with mental illness who are a danger to themselves or others, people with less severe mental health needs may find that no assistance is available. People can receive 24-hour, 7-day-a-week care outside of institutions through board-and-care homes, integrated service agencies, supportive housing, and other services, but these options are often limited. Persons with a mental illness, family members, and concerned neighbors may turn to local law enforcement officers, who are also available around-the-clock. Law enforcement officers can help mediate disputes or help an individual gain access to mental health services and the majority of these contacts do not result in arrest (Wolff, Diamond, & Helminiak, 1997). Officers, however, are not routinely trained to interact with people in the midst of mental health crisis, which can make a difficult situation worse (SAMHSA, 2000). Therefore, arrest may be the only option when community mental health services are not available.

Some people with serious mental illness are serious and violent offenders, and there is little disagreement that these offenders should be incarcerated and treated within the criminal justice system. Many individuals with mental illness who break the law commit nuisance crimes that are associated with their illnesses (Clark, McHugo, & Ricketts, 1999). Violations of this type include trespassing, vagrancy, and disturbing the peace. In these cases, officers must use their discretion in determining whether to arrest the person or help him or her enter the mental health service system.

There are also practical considerations that often encourage law enforcement personnel to take a person to jail rather than arrange mental health care. For instance, few communities offer 24-hour stabilization or crisis centers. Law enforcement personnel may be reluctant to take an offender to a psychiatric facility where custody and security are limited, or where the officer must wait for hours before the person is admitted. Access to mental health programs is limited by eligibility rules; the criminal justice system does not refuse anyone. The mental health system has long waits and limited beds; jails guarantee at least a minimum of security and control. Unlike the mental health system, which may challenge the officer's determination that the person suffers from mental illness, the criminal justice system doesn't question the officer's judgment for making an arrest (Lamb & Weinberger, 1998). Law enforcement officers frequently are forced to either abandon the individuals they encounter or make an arrest, relatively certain that the person will qualify for mental health services while in jail. Arrest may be the only viable option to ensure public safety.

Officials throughout the criminal justice system, from law enforcement and the courts, to corrections and parole, often lack sufficient knowledge about mental illness. Although a minimal level of treatment may be guaranteed in these settings, it is rarely part of a comprehensive treatment plan (Vacca, 1999).

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## **More Persons with Mental Illness in the Criminal Justice System**

The number of persons with mental illness in the criminal justice system is increasing for two reasons.

- 1) Without access to community-based mental health services, people with serious mental illness often have no other place to go. A subset of this population becomes homeless, medicates themselves with street drugs, and experiences crises in public settings, attracting the attention of police.
- 2) The overall number of people in jails and prisons has increased with the advent of tough-on-crime policies. Stricter laws have resulted in the incarceration of a wider range of offenders.

Since 1980, the country's overall incarceration rate has quadrupled. As of July 2001, there were 1.2 million state prison inmates and 150,000 federal prison inmates. Since 1990, this represents a 75% increase in state inmates and a 100% increase in federal inmates (U.S. Department of Justice, 2000). Researchers in Vermont found that individuals with mental illness were arrested more often than the general population (7.2% versus 1.7%). Consumers with substance abuse histories were even more likely to be arrested (14.4%) (Lamb & Weinberger, 1998).

Persons with mental illness who enter the criminal justice system have often had substantial prior involvement. The percentage of jail inmates with six or more prior sentences is 30.8% compared to 25.6% for inmates with mental illness. Experiences during incarceration are rarely pleasant. Inmates with mental illness are frequently ostracized and more likely to have discipline problems as a result of their illness and its symptoms. State prison inmates with mental illness serve sentences that average about 12 months longer than the sentences of other inmates (U.S. Department of Justice, 1999).

According to Fred C. Osher, M.D., director of the Division of Community Psychiatry at the University of Maryland, there are as many people with mental illness leaving the correctional system as there are entering the system. The process mimics the deinstitutionalization dilemma faced in the 1980s. Incarceration offers housing, food, shelter, and clothing to individuals who lack these necessities (U.S. Department of Justice, 2001). Complicating the problem is the vexing question of how to provide adequate wraparound care following release from jail or prison. Parole officers are burdened with huge caseloads, making it impossible for them to handle mental health needs.

Mental health advocates claim that mental illness has been criminalized. Individuals who are unable to gain access to services are arrested for committing crimes of survival or for publicly displaying symptoms of untreated mental illness such as camping in public, urinating on private property, and "felony mouth" aggressive confrontations with police. Homeless people who suffer from paranoia and symptoms of the illness commit these crimes (Little Hoover Commission, 2000).

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Some advocates fear that managed mental health care will exacerbate the problem by further limiting services and shifting costs from community mental health to the criminal justice system. This trend may continue to escalate as mental health budgets feel the squeeze of tighter state budgets. Others suggest more liberal commitment laws that would force a greater number of “non-compliant” individuals into either inpatient or outpatient treatment rather than allow them to live on the streets untreated. The California legislature has debated such a law change for two years, and New York implemented a broader outpatient commitment law following a 1999 subway fatality committed by a man diagnosed with schizophrenia. Long term outcome studies have not been conducted that demonstrate the success of these coercive measures, and the civil rights issues inherent in forced treatment remain controversial.

A three-year study of an involuntary outpatient commitment program at Bellevue Hospital in New York City found positive outcomes for persons with serious mental illness who were committed to outpatient treatment. The 1998 study found that the control group, which received enhanced mental health services without a court order, also experienced positive outcomes. For subjects under court order, the proportion of readmission dropped from 87.1% to 51.4%. For the control group, readmissions dropped from 80% to 41.6% (*Mental Health Weekly*, 1998).

One month after the study’s release, a man suffering from schizophrenia pushed Kendra Webdale off a Manhattan subway platform into the path of an oncoming train. The incident provoked a strong push for New York State’s outpatient commitment law, known as “Kendra’s Law.” The law’s opponents argued unsuccessfully that most “non-compliance” resulted from a non-responsive mental health system. A subsequent investigation by *The New York Times* supported the assertion that the mental health system was ultimately unresponsive. It found that Andrew Goldstein, the man who pushed Kendra Webdale to her death, had repeatedly sought treatment for his illness (Winerip, 1999).

A recent event suggests that the new outpatient commitment law is not a panacea for gaps in the treatment system. In March 2002, Peter J. Troy entered a Catholic church on Long Island and opened fire, killing a priest and a 73-year-old parishioner. A year earlier, Troy had twice been detained by police and admitted to psychiatric wards. Both times a judge ordered him to be released, and a county mental health agency failed to locate him for follow-up care (Lambert, 2002).

### **The Role of Substance Abuse and Homelessness**

Unstable housing and limited substance abuse treatment increase the likelihood that persons with a mental illness will become involved in the criminal justice system. A 1999 study published in *Psychiatric Services* followed 203 participants enrolled in a specialized treatment program for people with co-occurring mental and substance abuse disorders. The study found that participants were four times more likely to have encounters with the legal system that did not result in arrest, than they were to be arrested (Clark, et. al., 1999). Although continued substance abuse and unstable housing were associated with a greater likelihood of arrest, arrests for study participants declined over

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time. Poor treatment engagement was associated with multiple arrests, men were more likely to be arrested, and women were more likely to be victims of crime.

The study concluded that effective substance abuse treatment for persons with mental illness appears to reduce arrests and incarcerations, not the frequency of non-arrest encounters (Clark, et. al., 1999). According to statistics compiled by the Judge David L. Bazelon Center for Mental Health Law (2000):

- ◆ forty-seven percent of federal prisoners with mental illnesses were under the influence of alcohol or drugs at the time of the offense;
- ◆ fifty-nine percent of state prisoners with mental illnesses used drugs or alcohol at the time of the offense;
- ◆ sixty-five percent of local jail inmates with mental illnesses used alcohol or drugs at the time of the offense;
- ◆ an estimated 34% of mentally ill state prisoners, 24% of federal prisoners, and 38% of local jail inmates have a history of alcohol dependence; and
- ◆ thirteen percent of the prison population and 5% of jail inmates have both a serious mental illness and a substance abuse disorder.

Upon release, inmates with serious mental illness face a real risk of homelessness.

- ◆ Nineteen percent of federal prisoners with mental illnesses were homeless within one year of arrest, compared to 3% of other inmates.
- ◆ Twenty percent of state prisoners with mental illnesses were homeless within a year of arrest, compared to 9% of other inmates.
- ◆ Thirty percent of local jail inmates with mental illnesses were homeless within a year of arrest, compared to 17% of other inmates.

Inmates with mental illness also are more likely to be unemployed at the time of arrest; to have grown up in a foster home, agency, or institution; to have been physically or sexually abused while growing up; and to have grown up with a parent who abused alcohol (Judge David L. Bazelon Center for Mental Health Law, 2000).

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## Potential Solutions

Responses to the problem of criminalization are as diverse as the communities affected by it. Diversion programs, often created in collaboration between the mental health and criminal justice systems, are designed to avoid or shorten law enforcement detention of persons with mental illness.

Diversion programs can be divided into four categories:

- 1) pre-booking, which provides community-based services as an alternative to arrest;
- 2) post-booking, which encourages the individual's involvement in community mental health programs with court agreement;
- 3) post-arraignment, which negotiates treatment plans with multiple players, including the person who requires services, and representatives of community mental health, jail, court, probation/parole, and pre-trial service providers; and
- 4) mixed, which includes combinations of pre-booking, post-booking, and post-arraignment diversion options.

Key components of successful diversion programs include case management; training to work with individuals with a mental illness; aggressive identification of appropriate cases within the first 24-48 hours of detention; and competent data systems to track individuals through criminal justice and mental health systems (Backer, Howard, Jacobs, & Richardson, 1997). Most diversion programs only focus on the person after an arrest has occurred, but greater savings result from providing alternatives to arrest, such as improved police training, more 24-hour assistance centers, and expansion of supportive housing programs. States are beginning to invest in programs designed to divert people with serious mental illness from the criminal justice system, into treatment.

Initial results look promising, demonstrating that diversion programs can reduce the number of persons who return to custody. Under California's integrated-services program for homeless adults, persons with mental illness needs have spent 74% less time in jail. The state also has established a conditional release program that has shown initial success in reducing re-arrest rates (California Department of Mental Health, 2000).

The bulk of most states' efforts focus on individuals who have already been arrested. But, waiting to provide mental health services until a person is in jail ensures that the services are provided in the least appropriate setting at the highest cost. The ability of a mental health system to effectively respond to persons in crisis can result in significant cost savings in terms of overall public spending. The availability of a mental health professional through 24-hour crisis services and prevention programs can offer support and recovery services for the individual at the onset of a problem, which would help resolve the individual's immediate needs and help the person live independently within the community.

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Post-booking diversions, on the other hand, require an initial police response, an initial period of incarceration in most cases, and the involvement of the court and other law enforcement personnel. Researchers working with the federal government's Substance Abuse and Mental Health Services Administration (SAMHSA) are comparing the effects of pre-plea and post-plea interventions. Preliminary findings suggest that pre-plea interventions have greater potential for cost savings since they involve less jail and court time, but post-plea interventions have greater potential for success because the court is in a stronger position to negotiate a person's participation in treatment (Farley, 2000).

Once a criminal charge is filed, judges have limited ability to divert individuals out of the criminal justice system. This limitation may begin to change as mental health courts become more accepted across the country. In late 2000, President Clinton signed a bill establishing a demonstration program to help state, local, and Indian tribal governments create mental health courts. Mental health courts offer coordinated services for persons with mental illness, mental retardation, or co-occurring mental illness and substance abuse who have been charged with misdemeanors and nonviolent offenses. Successful mental health courts established in Broward County, FL, and King County, WA, served as models for the federal legislation.

Mental health courts established under the demonstration program have to include training of justice personnel, voluntary mental health treatment imposed by the courts, centralized case management that coordinates all mental health and social services, and continuing supervision of treatment plan compliance during the probationary period. Congress made an additional \$10 million available for diversion programs for people with mental illness as part of the Children's Health Act of 2000. The jail diversion grants are administered through the Department of Justice.

The best promise for addressing mental health needs in a cost-effective and clinically beneficial manner is to reach the person prior to their entering the criminal justice system. Community treatment programs have greater flexibility than jail-based mental health treatment programs. It is less expensive to serve these individuals in a community setting. Persons with a mental illness can qualify for Medicaid and other grant-based services that are unavailable when they are in jail. Most mental health consumers who commit minor crimes, such as trespassing and disorderly conduct, can easily be diverted into community services. Research on well-established diversion programs has also found that psychiatric emergency teams have been able to divert almost all persons they encountered into mental health services, including those with a history of substance abuse and violence (Lamb & Weinberger, 1998).

### **Police Teams Improve Coordination**

Appropriate training for law enforcement officers shows promise, improving their ability to work with people with a mental illness in ways that avoid violent confrontations and encourage beneficial relationships. This solution creates better links between mental health staff and local law enforcement officials. One of the first programs in the nation is the Memphis, TN Police Department's Crisis Intervention Team (CIT). CIT officers are regular patrol officers who have gone through an intensive 40-hour training program to learn how to respond to crises involving persons with serious mental illness. These

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officers respond to any 911 Call involving a mental health component. An important part of the CIT program is its partnership with the University of Tennessee Medical Center. At the discretion of CIT officers, a person may be brought to the hospital 24-hours-a-day, 7-days-a-week. The officers are able to leave the individual in a secure facility—with criminal, medical, and psychiatric treatment units—and be back on patrol in 15 minutes (U.S. Department of Justice, 2000). Police departments in Albuquerque, NM, Portland, OR, San Jose, CA, Seattle, WA, and Waterloo, IA have also begun to incorporate the Memphis model.

The Los Angeles County Mental Evaluation Team (MET) takes a slightly different approach, pairing an officer and a mental health professional to respond to police calls involving individuals with a mental illness. This arrangement allows for more people to be directed into treatment rather than incarceration.

### **States Have Crafted Innovative Responses**

California has taken a two-pronged approach to breaking the cycle of the revolving door. In fiscal year 1999-2000, the state funded \$10 million for the integrated services program for homeless adults. The purpose of the pilot program, which started in three counties, was to determine whether comprehensive services could keep adults with serious mental illness from becoming homeless or going to jail. The state also has issued Mentally Ill Offender Crime Reduction Grants to assist counties in reducing crimes and offenses committed by persons with serious mental illness. The state legislature approved more than \$100 million to support local programs designed to improve prevention, intervention, and incarceration services for persons with mental illness who become involved with the criminal justice system.

These conditional-release program funds have been used to establish mental health courts, improve reintegration services for offenders with mental illness upon release from jail, improve jail assessment and treatment services, and provide diversion opportunities for repeat offenders (Little Hoover Commission, 2000). Recently, Gov. Gray Davis signed a law establishing the California Council on Mentally Ill Offenders as part of the state's Youth and Adult Correctional Agency. The council, modeled after the Texas Council on Offenders with Mental Impairments, is intended "to investigate and promote cost-effective approaches to meeting the long-term needs of adults and juveniles with mental disorders who are likely to become offenders or have a history of offending" (State of California Senate Bill 1059, 2001).

### **Data Analysis Can Guide Responses**

States run the risk of implementing policies without a sufficient analysis of need. Reducing criminalization requires a coordinated response from both the mental health and criminal justice systems. The best way to achieve this is to first accurately identify what the problems are and where they occur. Policy makers can develop appropriate and cost-effective responses by conducting a detailed analysis of arrest and jail trends.

To develop these responses, policy makers need a firm understanding of the conditions that result in persons entering the criminal justice system and the diversion options

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available in order to keep them from drawing criminal justice resources away from serious offenders. States that already have diversion and prevention programs in place need to determine if these programs offer the most cost-effective responses to the criminalization of mental illness (Little Hoover Commission, 2000). Policy makers must determine which combination of strategies—diversion, coordination, prevention, and community-based mental health care—will result in the most effective approach.

In its 2000 report, the Little Hoover Commission recommended that California take the actions to ensure that no one enters the criminal justice system as a result of inadequate mental health care. The following three main recommendations are also applicable to other states.

- ◆ *Use data to improve services.* The state should analyze criminal justice and mental health data to identify priorities, develop promising programs and inform policy decisions that would reduce the number of persons with mental illness who end up in the criminal justice system.
- ◆ *Identify needs.* The state should document the need in each county for services that would prevent people from ending up in the criminal justice system, such as 24-hour crisis programs, supportive housing, and substance abuse treatment.
- ◆ *Evaluate intervention programs.* The state should determine whether diversion programs already in place represent the best opportunities for reducing involvement in the criminal justice system (Little Hoover Commission, 2000).

Combining the two separate data systems would enable state and local officials to more precisely determine the kinds of individuals who are most likely to become involved in the criminal justice system and to what extent. Reviewing the treatment histories of individuals in the jail and prison systems could further inform policies on treatment approaches, integrating services, and linking mental health services delivered in jails and prisons with those provided in community-based settings. A focused analysis of existing data could improve the ability of state officials and lawmakers to identify services at the point where they are most effective. A careful analysis of mental health and criminal justice data could help answer some of the following questions.

- ◆ What is the prevalence of crime among active individuals currently receiving services in community mental health systems?
- ◆ How does involvement with the criminal justice system by persons with mental illness compare with the general population's overall involvement with the system?
- ◆ What types of crimes are individuals with mental illness likely to commit?
- ◆ Are these persons arrested most often for crimes of survival, as anecdotal evidence suggests?

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- ◆ Do patterns of arrest and release suggest that law enforcement officials make “mercy bookings” when community-based mental health services are unavailable?
  - ◆ Are intervention and diversion programs available to persons most in need of them? Do they benefit from the interventions?
  - ◆ Which counties or localities have the highest rate of involvement with the criminal justice system by individuals with a mental illness, and for what types of behavior? Do they receive funding for intervention programs?
  - ◆ Do individuals with mental illness who also have a history of involvement with the criminal justice system have access to community mental health resources equal to that of other persons? (Pandiani, et. al., 1999).

### **The Challenge of Coordination**

Local and state agencies have failed to integrate mental health and criminal justice services. People with mental health needs are released from jails and prisons without adequate services, often resulting in re-arrest. The problem can be expensive; for example, California’s prisons and jails hold about 30,000 individuals with mental health needs. The majority of these persons are incarcerated for non-violent crimes. The state spends between \$1.2-\$1.8 billion annually to treat, process, and hold these individuals. Upon release, they are on their own to negotiate California’s network of community mental health systems. Mental health programs and community parole and probation programs do not work together to reintegrate these people into their communities (Torrey, Stieber, Ezekiel, Wolf, Sharfstein, Noble, & Flynn, 1992).

Community mental health and criminal justice agencies seldom work together. They compete for funding, have priorities and mandates that are often at odds with each other, and lack a culture and history of shared values. Despite estimates that 40% of persons receiving public mental health services will be arrested during their lives, these two public agencies do not routinely collaborate. State prisons and parole services also compete with county programs for resources. Limited funding forces county mental health programs to ration care to the general population. They are reluctant, if not unable, to provide services to persons with mental illness on parole and under supervision of the state.

Individuals with mental health needs leaving the criminal justice system face multiple barriers to community re-integration. These persons may require housing, employment, substance abuse treatment, and independent-living services in order to prevent their return to custody. When such an individual is preparing to leave jail, an outreach worker may visit to explain what community resources are available upon release. These workers may offer meal and hotel vouchers and can help re-establish public assistance or access to community programs, but often that is the only support the person receives.

The biggest barrier to a person’s successful reintegration back into the community is a lack of cooperation among state and local agencies. In Sacramento County, CA, for

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example, nearly 100% of persons involved in the criminal justice system have a history of contact with county mental health services. Parole and local mental health services do not coordinate care, share treatment history, or collaborate on discharge planning. Individuals released from the Sacramento County jail are directed to an outreach trailer located two miles away, across a train yard through open fields. The county has one of the state's more coordinated community mental health systems, but its law enforcement and mental health agencies have been unable to improve linkages and coordination (Little Hoover Commission, 2000). California has plenty of company, despite compelling evidence that coordinated services increase participation in treatment services and reduce recidivism rates, most states offer limited direction or incentive for collaboration.

Community mental health programs and local criminal justice systems often operate at cross-purposes and without mutual trust. Non-emergency community mental health programs do not generally operate after business hours and county jails routinely release mentally ill offenders between the hours of 9 p.m. and 2 a.m. with limited or no release planning. In a 1999 class-action lawsuit filed against some New York City agencies, plaintiffs charged that treatment planning was woefully lacking at city jails. They claimed that persons with mental health needs were often released from jail in the middle of the night and dropped off at a subway station with \$3 in tokens or MetroCard fare (*Brad H. v. the City of New York*, 1999).

Treatment plans in jail often differ from an individual's treatment plan in the community. This can be problematic, particularly because it takes many people weeks to adjust to a given psychotropic medication. Inconsistent treatment plans reduce the overall effectiveness of treatment efforts. A similar gap exists between prison-based services and community programs. Individuals with mental illness on parole from state prisons are often prevented from gaining access to community-based services. Cash-strapped county mental health departments insist that the state should serve the mental health needs of prison parolees. Parolee outpatient staff say they are unable to assist people with mental health needs with critical support services such as housing, independent living skills, and vocational rehabilitation (Little Hoover Commission, 2000).

Parole officers are trained to ensure that persons on their caseloads follow the rules; the officers are not trained to help them become reestablished within the community. Research on the general prison population shows that less than five percent of inmates participate in reentry programs designed to improve their reintegration into society. The average parolee receives two 15-minute, face-to-face sessions a month with a parole agent. About 20% of parolees fail to maintain contact with their parole agent. Advocates contend that barriers and poor coordination between community mental health and state parole agencies conspire to return persons with mental illness to prison.

Parole violators constitute 71% of all admissions to state prisons, suggesting a major need for intervention during the parole process (Petersilia, 2000). Despite the high parole-revocation rate, states do not adequately consider the ability for support services such as housing and supported employment to prevent parolees from returning to custody.

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## **Innovative Approaches**

Across the country, programs have begun to demonstrate the potential for coordinated efforts to reduce involvement in the criminal justice system by persons with mental health needs. Several states, as well as the federal government and local authorities, have developed strategies for linking and coordinating services for persons leaving correctional institutions.

- The National GAINS Center for People with Co-Occurring Disorders in the Criminal Justice System

This organization, based in Delmar, NY, disseminates information on effective mental health and substance abuse services for people with co-occurring disorders who come in contact with the criminal justice system. The center is a partnership involving SAMHSA, the National Institute of Corrections, the Office of Justice Programs, and the Office of Juvenile Justice and Delinquency Prevention.

The center brings together researchers, policy makers, practitioners, individuals with mental illness, and family members to gather information on the coordination of mental health and substance abuse services in criminal justice settings. It also provides technical assistance to programs that serve persons with mental health needs in courts, jails, prisons, probation, and parole (Little Hoover Commission, 2000).

- The Texas Council on Offenders with Mental Impairments

This council provides a formal structure for criminal justice, health and human services and other agencies to communicate and coordinate on policy, legislative, and programmatic issues affecting offenders with special needs. The council has been instrumental in improving service coordination and reducing state costs. It has developed a special-needs parole program for offenders who can be diverted from incarceration into cost-effective treatment alternatives. Some of these parole diversions enable the state to draw down federal reimbursements for services through Medicaid, Medicare, and Social Security. The council reports that for every dollar it spends on alternative programs, it draws down a dollar match from federal or other funding sources.

The council also has developed policies that have streamlined mental health assessments across local and state criminal justice programs and improved communication and coordination among agencies and programs. These efforts have reduced arrest and re-arrest rates for special needs offenders by 33% and have lowered the cost of parole aftercare (Texas Council on Offenders with Mental Impairments, 1998).

- Maryland's Community Criminal Justice Treatment Program

Maryland has improved the coordination of services and communication between mental health and criminal justice programs by creating a multi-agency collaborative that provides treatment and support services to offenders with mental illness. The state has programs in all 23 local jurisdictions, and each is led by a task force of state and local

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leaders. Services include crisis intervention, screening, counseling, discharge, and community service planning. The program provides transitional case management, long-term housing support, and substance abuse treatment. The goal of the program is to reduce criminal justice costs and disruptions, reduce the need for hospitalizations, and improve the ability of persons with mental illness to transition out of the criminal justice system (Conly, 1999).

- The Criminal Justice / Mental Health Consensus Project

The Project is an unprecedented, two-year national effort to prepare specific recommendations that local, state, and federal policymakers and criminal justice and mental health professionals can use to improve the criminal justice system's response to people with mental illness. Coordinated by the Council of State Governments, guided by a steering committee of six organizations, and advised by over 100 of the most respected criminal justice and mental health practitioners in the United States, the Consensus Project provides concrete, practical approaches that can be tailored to the unique needs of communities.

The *Consensus Project Report* is a collection of 47 policy statements created by the group to aid legislators, policymakers, practitioners, and advocates in making a broad systemic impact on the problem. The statements include specific recommendations to implement the policies, along with examples of programs, policies, or elements of state statutes that illustrate one or more jurisdictions' attempts to implement a particular policy statement (Criminal Justice/Mental Health Consensus Project, 2002).

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## Questions from the Correctional System

At the 2001 National Corrections Conference on Mental Illness, participants discussed future initiatives and planning needs that could help bring the mental health and criminal justice systems closer together (U.S. Department of Justice, 2001).

- ◆ Centralization of discharge planning at state prisons is one innovation that could promote consistent collaboration and follow-through. New York has tried centralizing discharge through one facility.
- ◆ More information is needed about the progress of mental health courts. How are people assessed to gain access to mental health courts?
- ◆ Is punishment a viable option for non-compliance? Punishment is used for non-compliance in drug courts. Should punishment be used for non-compliance in mental health courts?
- ◆ Research on the effects of outpatient commitment is needed. In the absence of enhancements and increased services, there is an assumption by some that extended laws for involuntary confinement will have a big effect. As of now, no proof exists.
- ◆ Is treatment oversold as a reducer of recidivism? Do treatment proponents promise more than can be delivered?

The conference also generated recommendations to develop a standardized assessment tool that would allow corrections staff to:

- ◆ diagnose mental illness by level and severity;
- ◆ develop a mental health classification system for offenders; and
- ◆ identify exact numbers of persons with mental illness in correctional facilities.

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## Conclusion

It will not be easy to implement workable solutions to the problem of criminalization of persons with serious mental illness.

However, as detailed above, several organizations across the country are making progress toward finding solutions that could halt and ultimately reverse the trend to criminalize mental illness. With examples such as the Memphis Police Department's Crisis Intervention Team on the front lines, the National GAINS Center providing information on local initiatives, and the Council of State Governments' *Criminal Justice / Mental Health Consensus Project* detailing bipartisan recommendations for policy improvement at local, state, and federal levels, momentum is building on several fronts.

Despite the barriers of turf battles, budget pressures, and competing priorities within each system, the criminalization of persons with mental illness needs to be addressed in a consistent, persistent manner. State mental health agencies must be willing to take a leadership role to forge stronger links with the criminal justice system and to make lawmakers, other state officials and the general public more aware of these pressing problems.

The key is in recognizing that the criminalization of persons with mental illness is a challenge shared by many disciplines. If this recognition occurs, law enforcement officials can dedicate their resources to violent offenders, and mental health leaders can respond more effectively to the needs of individuals with mental illness and their families.

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