

***The Criminal Justice/
Mental Health Consensus
Project***

Introduction

The *Criminal Justice/Mental Health Consensus Project* is a broad-based, national effort to improve the response to people with mental illness who come into contact (or are at risk of coming into contact) with the criminal justice system. This report provides policymakers, practitioners, advocates, and others determined to address this issue with an array of options and ideas, many of which have emerged in communities across the country.

This report has a broad target audience best characterized as “agents of change.” Defined as a wide range of leaders in communities and states, change agents may be state elected officials such as legislators or appointed administrators and their staffs who can consider and address the broad policy issues that have profound implications at the community level. Because this is a community problem, however, the change agents must also include a wide range of community players, starting with those most closely affected by the problem. They can use the recommendations found in this report

to strengthen community structures, and they can work with policymakers to ensure that solutions they craft are practical and effective.

Perhaps the most valuable aspect of this report is that it reflects a consensus among the stakeholders in the criminal justice and mental health system. Police professionals, district attorneys, public defenders, judges, state corrections directors and jail administrators, community corrections officials, state mental health directors, local mental health and substance abuse treatment providers, clinicians, crime victims, consumers, mental health advocates, and others have all had input into the report. Legislators, policymakers, practitioners, and other agents of change can champion and implement the detailed recommendations in this report knowing that each has been developed and approved by experts from an extraordinarily diverse range of perspectives who work in and administer the departments, agencies, and organizations trying every day to address the needs of people with mental illness in the criminal justice system.

What, exactly, is the problem? How did it develop? Who can fix it? What can they do? And where do they start? This report addresses these questions. State and local government officials and community leaders can use the policy statements provided in this report to get beyond discussing the issue and to begin developing initiatives that will address the problem. Furthermore, the report enables agents of change to cite programs and practices that demonstrate that there are in fact jurisdictions that have already taken steps to implement a particular policy statement.

Having all of this information in one document, which reflects countless hours of counsel from over 100 of the most respected criminal justice and mental health practitioners and policymakers in the United States, is unprecedented. While this report by itself cannot change a community or system, it is an extraordinary resource in the hands of a person committed to improving the criminal justice system's response to people with mental illness.

THE PROBLEM

People with mental illness are significantly overrepresented among the segment of the population in contact with the criminal justice system. Approximately 5 percent of the U.S. population has a serious mental illness.¹ The U.S. Department of Justice reported in 1999, however, that about 16 percent of the population in prison or jail has a serious mental illness.² Of the 10 million people booked into U.S. jails in 1997, at least 700,000 had a serious mental illness; approximately three-quarters of those individuals had a co-occurring substance abuse disorder.³ A study conducted in New York State found that men involved in the public mental health system over a five-year period were four times as likely to be incarcerated as men in the general population; for women, the ratio was six to one.⁴

Impact of the Problem on People and Systems

How elected officials and the public understand mental illness as it relates to the criminal justice system often is informed by newspaper and television headlines, which typically focus only on the most egregious manifestations of the problem: a screwdriver-wielding woman with mental illness shot dead by officers who subsequently tell of being frightened and confused themselves; a crime victim outraged that, before assaulting her, a person with a history of untreated mental illness bounced between community mental health centers, state hospitals, and the local jail.

Although these tragedies sometimes drive policymaking, they are not the cases involving mental illness most familiar to police officers, prosecutors, defense attorneys, judges, corrections administrators, parole and probation officers, and other criminal justice personnel. These criminal justice practitioners are all too familiar with the following scenarios:

- A police officer returns countless times to a house or street corner in response to a call for assistance involving the same person with a history of mental illness; each time, the officer is unable to link the person to treatment.
- Month after month, a prosecutor charges the same person with committing a different public nuisance crime, and, each time, the defendant with mental illness pleads guilty to time served.

1. R. C. Kessler et al., "A Methodology for Estimating the 12-Month Prevalence of Serious Mental Illness," In *Mental Health United States 1999*, edited by R.W. Manderscheid and M.J. Henderson, Rockville, MD, Center for Mental Health Services.

2. Paula. M. Ditton, *Mental Health Treatment of Inmates and Probationers*, Bureau of Justice Statistics, U.S. Department of Justice, July 1999. The prevalence statistic for mental illness in U.S. jails and prisons was gathered through a combination of inmate self-reporting and mental health treatment history. Inmates in the sample qualified as having a mental illness if they met one of the following two

criteria: "They reported a current mental or emotional condition, or they reported an overnight stay in a mental hospital or treatment program." To account for inmate underreporting of their mental health problems, admission to a mental hospital was included as a measure of mental illness. Ten percent of inmates reported a current mental condition and an additional six percent did not report a condition but had stayed overnight in a mental hospital or treatment program.

3. Linda Teplin and Karen Abram, "Co-Occurring Disorders among Mentally Ill Jail Detainees: Implications for Public Policy," *American Psychologist* 46:10, October 1991, pp. 1036-45.

- Jail and prison administrators watch their systems swell with these individuals, who spin through the revolving door of the institution. Corrections officials' job is to keep these inmates alive, even if that means isolating them in administrative segregation with no outside contact for weeks on end. When the release date comes around, freedom for many prisoners is only temporary, unless they are among the few for whom reentry has meant planning and linkage with community supports.
- A parole officer already struggling with an overwhelming caseload is assigned an individual with mental illness released from prison; the officer receives only limited support from the community-based mental health program. The parolee is rearrested and returned to prison when he commits a new crime—urinating on a street corner and making lewd gestures to frightened people passing by—displaying in public the symptoms of his untreated mental illness.

Each of these situations frustrates criminal justice officials; they know they are failing the person who suffers from mental illness and his or her loved ones. Encounters between people with mental illness and law enforcement sometimes end in violence, jeopardizing the safety of consumers and officers. Once incarcerated, people with mental illness become especially vulnerable to assault or other forms of intimidation by predatory inmates.⁵ People with mental illness also tend to decompensate in prisons and jails—environments that exacerbate the symptoms of mental illness—and there they are at especial risk of harming themselves or others. Upon their return to the communities they left behind during their incarceration, they discover that their criminal records have, in many cases, made it even harder to obtain access to treatment.

Criminal justice officials may lose sight, however, of the lives these individuals lead. These are sons and daughters, fathers and mothers, who struggle daily to fend off symptoms of mental illness. Without adequate treatment, their disease may disable them significantly. Some experience delusions and may be convinced that strangers are planning to attack them. In other cases, depression immobilizes them; overcome with a sense of hopelessness, their physical strength deteriorates. Many of them are people who've spent years trying to mask torments or hallucinations with alcohol or any street drug they could scrape together enough money to buy and now are dependent on these substances to avoid withdrawal states and further decompensation. Often, their

"Inmates, families, guards, judges, prosecutors and police are in unique agreement that our broken system of punting the most seriously mentally ill to the criminal justice system must be fixed."

**U.S. CONGRESSMAN
TED STRICKLAND**
Ohio

Source: U.S. House Committee on the Judiciary, Subcommittee on Crime, Terrorism, and Homeland Security. *The Impact of the Mentally Ill on the Criminal Justice System*. 107th Congress, September 21, 2001

4. Judith F. Cox, Pamela C. Morschauser, Steven Banks, James L. Stone, "A Five-Year Population Study of Persons Involved in the Mental Health and Local Correctional Systems," *Journal of Behavioral Health Services & Research* 28:2, May 2001, pp. 177-87. This study used data from the mental health and criminal justice systems of 25 upstate New York counties. The study defines individuals who have been in the public mental health system as having been in a state-run psychiatric inpatient facility or a local psychiatric inpatient facility, or having received mental health services from a local, general hospital using Medicaid coverage. Incarceration was defined as having spent at least one night in jail during the five-year study period.

5. See testimony of Reginald Wilkinson, then vice president, Association of State Correctional Administrators and director, Ohio Department of Rehabilitation and Correction, before the House Judiciary Committee, Subcommittee on Crime, Terrorism and Homeland Security, oversight hearing on "The Impact of the Mentally Ill on the Criminal Justice System," September 21, 2000, available at: www.house.gov/judiciary/wilk0921.htm.

exhausted families have run out of the funds and emotional resources to take care of them.

Sometimes, when the criminal justice and mental health systems let someone with mental illness fall through the cracks, a stranger is harmed and justifiably motivated to demand accountability from the person with the mental illness and the public health system that failed. More often, when a person with a mental illness does assault someone, the victim is a family member, friend, or acquaintance.⁶ Whether relatives or strangers, the victims are usually left to make sense of the baffling interface between the criminal justice system and the mental health system.⁷

The current situation not only exacts a significant toll on the lives of people with mental illness, their families, and the community in general, it also threatens to overwhelm the criminal justice system. Police departments dedicate thousands of hours each year transporting people with mental illness to hospitals and community mental health centers where staff often are unable to admit the individual or quickly return him to the streets. Judges, prosecutors, and defense attorneys race through backlogged dockets, disposing of most cases in minutes, but find that the symptoms and behaviors of the growing numbers of defendants with mental illness who appear in their courtrooms cannot be processed as quickly. On any given day, the Los Angeles County Jail holds as many as 3,300 individuals with mental illness—more than any state hospital or mental health institution in the United States.⁸ Without adequate planning to transition inmates with mental illness back into the community, many will quickly return to jail or prison; recidivism rates for inmates with mental illness can reach over 70 percent in some jurisdictions.⁹

Every criminal justice professional would agree that the system has inherited a problem of enormous scope and complexity. Police, courts, and corrections officials feel they're boxed in. Resources are stretched to the limit: they're tight on money and even tighter on time. Under the circumstances, many have tried to find a way to serve people with mental illness more efficiently. But with limited options and resources, especially in rural areas, many criminal justice practitioners are frustrated because they know what they're doing isn't enough.

"It is unacceptable that Los Angeles County and New York jails have essentially become the largest mental health care institutions in our country—these are jails, after all, not mental health facilities."

**U.S. SENATOR
MIKE DEWINE**
Ohio

Source: U.S. House Committee on the Judiciary, *The Impact of the Mentally Ill on the Criminal Justice System*. September 21 2001

6. Ditton, *Mental Health and Treatment*, 4. More than 60 percent of the victims of violent crimes committed by state prisoners with mental illness were known to the offenders.

7. People with mental illness who themselves are the victims of a crime are a notable subset of this population. While especially in need of support services, they in particular suffer from insufficient coordination between criminal justice and mental health systems. Although some recommendations in this report address this population, the issue of victims with mental illness is generally beyond the scope of this report.

8. *Sacramento Bee*, "Treatment Not Jail: A Plan to Rebuild Community Mental Health," March 17, 1999, Section B, p. 6.

9. Lois A. Ventura, Charlene A. Cassel, Joseph E. Jacoby, Bu Huang, "Case Management and Recidivism of Mentally Ill Persons Released From Jail," *Psychiatric Services* 49:10, Oct. 1998, 1330-37. This study examined the effect of community case management on recidivism for jail detainees who have mental illness. The study followed releasees for 36 months. Within the 36 months, 188 of 261

Origins of the Problem

Understanding why this problem has become so acute in recent years requires some familiarity with the dramatic shifts in mental health and criminal justice policy over the course of recent decades.

Few institutions have attempted so complete a change over the previous 35 years as has the nation's public mental health system. Once based exclusively on institutional care and isolation, the system has shifted its emphasis almost entirely to the provision of community-based support for individuals with mental illness. In 1955, state mental hospital populations peaked at a combined 559,000 people; in 1999 this number totaled fewer than 80,000.¹⁰ There are many reasons for this change; fiscal reality, political realignment, philosophical shifts, and medical advances, in no particular order, have all played a part. These forces and others have converged to create a reality that few could have envisioned when the Community Mental Health Centers Act was signed into law in 1964.¹¹

For many clients who utilize this system, successful community integration has indeed been achieved. Reliable data on the success of community mental health are difficult to find, but anecdotal experience shows that many people with active or past diagnoses of mental illness live and work "normally" in communities across the country. Their very success in achieving recovery helps them to mix unremarkably with their families, neighbors, and coworkers.

The mental health system today has powerful and effective medications and rehabilitation models with which to work. The professionals in the system know much about how to meet the needs of the people it is meant to serve. The problem comes, however, in the ability of the system's intended clientele to access its services and, often, in the system's ability to make these services accessible. The existing mental health system bypasses, overlooks, or turns away far too many potential clients. Many people the system might serve are too disabled, fearful, or deluded to make and keep appointments at mental health centers. Others simply never make contact and are camped under highway overpasses, huddled on heating grates, or shuffling with grocery carts on city streets.

The lack of affordable, practicable housing options for individuals with mental illness compounds the difficulty of providing successful treatment. Without housing that is integrated with mental health, substance abuse, employ-

subjects (72 percent) were rearrested.

10. T.A. Kupers, *Prison Madness: The Mental Health Crisis Behind Bars and What We Must Do About It*, San Francisco, Jossey-Bass Publishers, 1999.

11. The public, the media, and even some in the criminal justice and mental health system, suggest that there is a causal connection between the dramatic reduction in the number of people in mental health institutions and the extraordinary growth of the prison and jail population. Some present two straight-line graphs to illustrate the point, implying that the very same people who used to be

in mental health institutions are now in prison or jail. In fact, no study has proven that there has been a transition of this population from one institution to another. Indeed, while the gross number of people with mental illness incarcerated has increased significantly in recent years, there is no evidence that the *percentage* of people in prison or jail who have a mental illness is any greater than it was 35 years ago when the *Community Mental Health Centers Act* was passed. See Henry J. Steadman et al., "The Impact of State Mental Hospital Deinstitutionalization on United States

ment, and other services, many people with mental illness end up homeless, disconnected from community supports, and thus more likely to decompensate and become involved with the criminal justice system. Most studies estimate that at least 20 to 25 percent of the single adult homeless population suffers from some severe and persistent mental illness.¹²

It is against this backdrop that officials in the criminal justice system have in recent years encountered people with mental illness with increasing frequency. Because of sensational news headlines or other sources that stigmatize mental illness, some criminal justice professionals may be prone to making the incorrect assumption—which most of the public makes—that mental illness by definition incorporates violent behavior.¹³ They may respond to situations on the street, in a courtroom, or at a parole board hearing on the basis of common but erroneous perceptions. In such instances, police, judges, and releasing authorities may be especially wary about releasing people with mental illness into the community.

Compounding the problems stemming from the stigma associated with mental illness, changes to criminal justice policies during the course of the last two decades have prolonged the involvement of people with mental illness in the criminal justice system. For example, in response to community or government leaders' demands to increase quality of life and to reduce crime and fear of crime, many police departments have instituted "zero tolerance" policies, arresting people committing offenses such as loitering, urinating in public, and disturbing the peace.¹⁷ Many individuals netted as a result of these tactics were people demonstrating in public the symptoms of untreated mental illness. The majority of these people also have a co-occurring substance abuse problem. As legislatures have increased the length of prison sentences (and frequently made them mandatory) for the possession or sale of some illegal substances, growing numbers of people with mental illness have been incarcerated—and for longer periods of time.

Already overcrowded and overburdened, prisons and jails typically are without the resources to ensure the availability of effective mental health treatment and appropriate medications. In these cases, a person with mental illness is likely to decompensate, exacerbating the symptoms of his or her mental ill-

Violence and Mental Illness

Popular beliefs about violence and mental illness do not jibe with reality. The results of several recent, large-scale research projects conclude that only a weak statistical association between mental disorder and violence exists.¹⁴ Serious violence by people with major mental disorders appears concentrated in a small fraction of the total number, and especially among those who use alcohol and other drugs and those without access to effective services.¹⁵ Indeed, the vast majority of people with mental illness are not violent; they are more likely to be victims of crime than they are likely to harm others.¹⁶

Prison Populations, 1968-1978," *Journal of Criminal Law & Criminology* 75:2, 1984, pp. 474-90.

12. Paul Koegel et al., "The Causes of Homelessness," in *Homelessness in America*, 1996, Oryx Press. However, according to the Federal Task Force on Homelessness and Severe Mental Illness, only approximately 5 percent of people with severe mental illness are homeless on a given day. Federal Task Force on Homelessness and Severe Mental Illness, 1992, *Outcasts On Main Street: A Report of the Federal Task Force on Homelessness and Severe Mental Illness*, Washington, D.C., GPO. For more information on homelessness and mental illness see A.D. Lezak and E. Edgar, *Preventing Homelessness Among People with Severe Mental Illness*, Rockville, MD, Center for Mental

Health Services, 1999 and The National Resource Center on Homelessness and Mental Illness, *National Organizations Concerned with Mental Health, Housing, and Homelessness*, Delmar, NY, 2001, available at: www.nrchmi.com

13. U.S. Surgeon General, *Mental Health: A Report of the Surgeon General*, 1999, Available at: www.surgeongeneral.gov.

14. H. Steadman, E. Mulvey, J. Monahan, P. Robbins, P. Applebaum, T. Grisso, L. Roth, and E. Silver, "Violence by People Discharged From Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods." *Archives of General Psychiatry* 55, 1998, 393-401. See also K.T. Meuser, et. al., "Trauma and Post-Traumatic Stress Disorder in Severe Mental Illness," *Journal of Consulting and*

ness. As a result, the person may act out and fail to follow prison rules, which in turn extends the period of incarceration for the individual. For these reasons, people with mental illness tend to stay in jail or prison considerably longer than other general population inmates. For example, on Riker's Island, New York City's largest jail, the average stay for all inmates is 42 days, but it is 215 days for people with mental illness.¹⁸

Inmates with a mental illness who leave prison or jail are typically provided with just a short (two weeks or less) supply of medications and enough money to take a one-way trip on public transportation. Without housing, linkage to a community-based mental health treatment program, or other much needed services, the person typically returns to the type of behavior that originally contributed to his or her incarceration.

REASONS FOR HOPE

The good news is that the urgency of the problem has bred numerous workable options—within a framework of limited resources—in many communities across the country. These efforts span the criminal justice continuum, preceding arrest and continuing past incarceration and the individual's reentry into the community, and their success is often a function of the creation of partnerships, especially between the criminal justice and mental health systems. By forming partnerships police officers on the street, booking officers in the stations, jailers, judges, public defenders, prosecutors, probation officers, prison administrators, and parole officers have created service and diversion options that support their public safety functions, and, at the same time, ensure appropriate care of people with mental illness who come into their systems. Along with mental health providers, these partnerships may also include housing agency officials, substance abuse treatment providers, business owners, families, and people who themselves have a mental illness. Identifying and engaging others with a stake in the problem builds a support network for its solution. Partnerships create a framework for moving forward. They help identify community strengths and resources as well as deficits and needs. Most important,

Clinical Psychology 66:3, 1998, 493-99..

15. Ibid.

16. Virginia Hiday, Marvin S. Swartz, Jeffrey W. Swanson, Randy Borum, and H. Ryan Wagner, "Criminal Victimization of Persons with Severe Mental Illness," *Psychiatric Services* 50, 1998, pp. 62-68. This study tracked 331 involuntary mental health outpatients. The rate of nonviolent victimization for the study cohort (22.4 percent) was similar to that in the general population (22.1 percent). The rate of violent criminal victimization, however, was two and a half times greater than in the general population—8.1 percent compared to 3.1 percent. In multivariate analysis, substance use and transient living

conditions were strong predictors of criminal victimization.

17. Ditton, *Mental Health and Treatment*, 4. According to the Bureau of Justice Statistics, over one-quarter of the inmates with mental illness in local jails were incarcerated for a public order offense.

18. Fox Butterfield, "Prisons Replace Hospitals for the Nation's Mentally Ill," *New York Times*, March 5, 1998, A1. Refers to testimony of Dr. Arthur Lynch, director of Mental Health Services for the NYC Health and Hospitals Corporation, before the Subcommittee on Mental Health, Mental Retardation, Alcoholism and Drug Abuse Service (April 22, 1998).

"As a member of the Senate Appropriations Committee in Pennsylvania, I am acutely aware of the unsustainable rate at which the budgets for our county jail system and Department of Corrections are growing. We want to continue ensuring that we throw away the key when we lock up violent offenders. We cannot afford to maintain that practice if we continue incarcerating nonviolent offenders or misdemeanants who are in prison or jail only because they have a mental illness."

SENATOR ROBERT J. THOMPSON

Chair, Appropriations Committee, PA

Source: U.S. House Committee on the Judiciary, *The Impact of the Mentally Ill on the Criminal Justice System*. September 21 2001

perhaps, a community partnership becomes a single voice that demands attention and appeals convincingly for assistance needed to solve the problem.

The extent to which a partnership at the community level changes systems depends on the extent to which leaders emerge at the state level. State legislatures raise and appropriate money. They write laws that affect who gets into the criminal justice system and how they are treated. Public mental health systems are administered and funded at the state level, so decisions made there affect every community statewide. If the criminal justice system's encounters with people who have mental illness are to be changed, community partners and state policymakers must work together. This report should be exceptionally helpful in that regard.

HOW TO USE THIS REPORT

This report comprises 46 policy statements, each of which can serve as a guiding principle or as the underpinning of an initiative to improve the criminal justice system's response to a person with mental illness. Each policy statement is followed by a series of recommendations—lettered statements in bold text—highlighting the steps that should be taken to implement the corresponding policy. The policy statements and recommendations will help agents of change to focus their efforts on particular aspects of the interaction between individuals with mental illness and the criminal justice system.

Woven into the discussion of each recommendation are examples of programs, policies, or elements of state statutes that illustrate one or more jurisdiction's attempt to implement a particular policy. By highlighting certain approaches, however, the report is not promoting them as “best practices.” They are simply efforts that involve partnerships, resourcefulness, or even longtime practices for other communities to consider. (Programs, policies, and statutes highlighted in the text are, with some exceptions, described in more detail in Appendix B: Program Examples Cited in the Report.) Just as this report recognizes that each person with mental illness is unique, the report's authors understand that communities, their problems, and potential solutions vary considerably across the country. What works in one community may not be a perfect fit for its neighbor, let alone for a community halfway across the continent. Indeed, this report emphasizes that each community must find its own solutions to these complex and interwoven problems. The practices and approaches chosen for examples in this report are themselves continuing to evolve and adapt to changing community conditions.

The Target Population

Policy statements in this report address individuals whose behavior—not diagnosis alone—reflects some type of severe or serious mental illness. In addition, the target population for this project includes individuals who exhibit symptoms of brain injury, mental illness relating to aging (i.e., dementia), coexisting developmental disability, or co-occurring substance abuse problems. The target population excludes individuals who exhibit symptoms of character disorder, developmental disability, or substance abuse *only*.

The age of the target population is adult, with two exceptions. Recommendations that deal with local law enforcement contemplate juveniles whose age is often not immediately apparent to an officer. In addition, those recommendations developed for corrections administrators target adults as well as juveniles incarcerated in adult correctional facilities. (The situation involving juveniles with mental illness who come into contact with the criminal justice system is no less serious and in need of policymakers' attention than those problems regarding adults with mental illness who come into contact with the criminal justice system. Nevertheless, the systems that deal with the two age populations are distinct, and there were not sufficient resources available in this project to evaluate the problems regarding both adults and juveniles.)

Common Language, Common Terms

The two worlds of justice and mental health each have their own language, with terms that do not always easily translate into broader, more familiar words; for this reason, a comprehensive glossary is included as Appendix A. There are some terms, however, that appear throughout the document, and warrant explanation up front.¹⁹

co-occurring disorders. The term co-occurring disorders used throughout this manuscript refers to the combination of a substance use disorder with a non-addictive mental disorder. Although there may be other "co-morbid" conditions, especially in those with co-occurring disorders (e.g. HIV/AIDS, Hepatitis, or diabetes), because of the high frequency that addictive behavior occurs in individuals with mental disorders, co-occurring disorders are extremely relevant to this report. Other frequently used terms for this condition include; dual diagnosis, MICA (mentally ill substance abuser), and CAMI (chemical abuse and mental illness).

diversion. There are two distinct definitions that apply to the usage of the word in the text. The first, and most prevalent, means removing someone from the traditional track or expected process of the criminal justice system; police diversion (or pre-arrest diversion) means that the person is not taken into custody but either taken home, to some treatment or support system, or simply released in lieu of charging the person with a crime. Jail diversion means a judicial decision that pretrial release or probation is more appropriate than incarceration.

In Chapter 3: Pretrial Issues, Adjudication and Sentencing, however, there is a narrower definition employed, usually called "pretrial diversion". This term of art describes a process whereby prosecutors—and only prosecutors—may decide that bringing the full force of the justice process to bear in a particular instance is not warranted. This can occur for a number of reasons; the prosecutor might decide that since the defendant is a first-time offender and the charge is minor, it is simply not worth the systems time and resources to prosecute. Or the prosecutor might feel that having an offender go through the system would do the person more harm than good and society would, in the end, pay the price.

Usually when this second definition is used, there is a program that the defendant enters as part of a contract entered into between the defendant and the prosecutor. The defendant agrees to comply with certain conditions on his behavior for a fixed period of time; the state agrees to drop the charges if the defendant is successful.

jails and prisons. Jails are usually defined as the facility of incarceration that is used primarily for people awaiting trial and for those sentenced to short-usually one year or less-terms of incarceration. Jails are typically run by the county. The average

length of stay in jails is brief, measured in days rather than months or years, when compared with prisons. In most instances it is difficult to predict how long an individual will remain in jail, since many are there simply because they have not yet been able to make bail. Jails over the period of a year will have a much higher number of discrete individuals entering and leaving the facility than do prisons.

Unlike jails, prisons are state-operated and typically hold only those persons sentenced to over a year. Unlike jails, where there is a mix of pretrial and sentenced persons in the population, all people entering prison have fixed sentences defining how long they will remain incarcerated. The average lengths of stay in prison is always measured in years.

The inmate with a mental illness in a jail is there for a short period of time, is exposed to large numbers of inmates coming and going, is rarely able to become involved in an effective treatment protocol since their stay is likely to be short, and may have little understanding of why they are incarcerated, all contributing to a high level of stress and anxiety. The prison inmate on the other hand has time to develop a pattern for his days and usually has access to treatment for his illness. On the other hand, he will likely be incarcerated for years and will face numerous difficulties in adjusting to the outside world when finally released.

mental health. A state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with diversity. One person's understanding of mental health may differ from another's based on cultural values and other factors.

mental illness. The term that refers collectively to all diagnosable mental disorders.

mental disorders. Health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning such as Alzheimer's disease, depression, and Attention-Deficit/Hyperactivity Disorder.

Serious Mental Illness (SMI). A term defined by federal regulations that generally applies to mental disorders that interfere with some area of social functioning.

Severe and Persistent Mental Illness (SPMI). About half of those with serious mental illness were identified as being even more seriously affected, with diagnoses that includes schizophrenia, severe depression, bipolar disorder, panic disorder, and obsessive-compulsive disorder. Approximately 5.4 percent of the adult population is affected by SMI while roughly 2.6 percent of the population is affected with SPMI.

19. Definitions concerning mental health and mental illness are courtesy of the U. S. Department of Health and Human Services, Mental Health: A Report of the Surgeon General, Rockville, MD: 1999, pp. 4-5; 46.

The policy statements in the report are divided into two parts. Part One is organized according to events on the criminal justice continuum that provide significant opportunities to change the course of involvement a person with mental illness might have with the criminal justice system.²⁰ The first event (and the corresponding policy statement) addresses the obligation of the mental health system to minimize the frequency with which a person with mental illness comes into contact with police. Subsequent policy statements describe options that should be available and policies that should be in place for law enforcement, courts, corrections, and community corrections officials encountering people with mental illness.

Four themes recur throughout the first part of the report: 1) improving collaboration; 2) training staff; 3) building an effective mental health system ; and 4) measuring and evaluating outcomes. The policy statements in Part Two of the report are organized according to these overarching themes.

About the Target Population

The policy statements and recommendations for implementation in this report contemplate a broad spectrum of the population with mental illness in contact with the criminal justice system.

The report identifies approaches for addressing issues related to the inappropriate involvement of people with mental illness with the criminal justice system. It does not, however, set out to exonerate all people with mental illness of any wrongdoing, nor does it intend to insulate them from the consequences of their actions. Some people with mental illness may commit crimes for which they, like anyone else, should be arrested, prosecuted, or imprisoned. In these, as in all serious criminal cases, prosecutors, judges, and juries should consider all available evidence and decide accordingly. With this in mind, this report

Understanding the Target Population

Every person with mental illness who comes into contact with the criminal justice system is in some way unique. Many of the report's recommendations are based on this premise. The report also recognizes that the vast majority of people with mental illness function appropriately in the community and commit no crimes. Just the same, some generalizations can be made about the people with mental illness who are the focus of this report. They frequently are the poorest and most disabled citizens in the community.²² Many are homeless or inadequately housed.²³ In many communities, they are overwhelmingly people of color.²⁴ They face multiple stigmas, especially if they have histories of criminal justice involvement overlaid on their histories of mental illness. In many cases, they are detained or arrested for actions over which they have little choice or control, at least at the moment of apprehension. The majority uses and abuses street drugs or alcohol. Many have received little or no treatment for their mental illness.

20. This report does not attempt to discuss every event along the criminal justice continuum. Rather, specific events are discussed for which there is opportunity to change the typical interaction between a person with mental illness and the criminal justice system.

21. People who are found not competent to stand trial (and the process by which this occurs) are not the focus of this report. Although the public and some policymakers may be most familiar with cases involving pleas of not guilty by reason of insanity (or under new state laws, a conviction of "guilty but insane"), these cases in fact represent a very small fraction of the overall number of people with mental illness who come into contact with the criminal justice system. A 1996 study of the Baltimore Circuit Court estimated that of 60,432 indictments filed during one year, only eight defendants (.013 percent) ultimately pleaded not criminally responsible. All eight pleas were uncontested by the state. Jeffrey S. Janofsky, Mitchell H. Dunn, Erik J. Roskes, Jonathan K. Briskin, Maj-Stina Rudolph Lunstrum, "Insanity Defense Pleas in Baltimore City: An Analysis of Outcome," *American Journal of Psychiatry* 153:11, November, 1996, pp.1464-68.

22. P.M. Ditton, *Mental Health Treatment*. 38 percent of state and federal inmates with mental illness and 47 percent

of jail inmates with mental illness reported being unemployed in the month before their arrest.

23. Ibid. Though only approximately 5 percent of individuals with severe mental illness are believed to be homeless, Ditton found that 30 percent of jail inmates with mental illness and 20 percent of state prison inmates with mental illness reported living in a shelter in the 12 months prior to arrest; see also note 12.

24. One 1997 survey estimates that nearly 35 percent of the individuals receiving some form of mental health treatment (inpatient, residential, outpatient, etc.) are either black or Latino. Laura J. Milazzo-Sayre et. al., "Chapter 15: Persons Treated in Specialty Mental Health Care Programs, United States, 1997." The Center for Mental Health Services. An even greater percentage of the population in jail or prison that has a mental illness is disproportionately black or Latino. Sixty-two percent of prison inmates in 1999 were people of color. Black males have a 29 percent chance of serving time in prison at some point in their lives; Hispanic males have a 16 percent chance; white males have a 4 percent chance. Mark Mauer, *Intended and Unintended Consequences, State Disparities in Imprisonment*, The Sentencing Project, 1997.

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addresses people with mental illness who are at risk of involvement with the criminal justice system, people with mental illness who are charged with (or convicted of) committing misdemeanors and those who have been charged with (or convicted of) committing serious felonies.²¹

GETTING STARTED

The policy statements in this report make up a compendium of ideas, recommendations, and innovative examples that have worked well in different places around the country and therefore should at least be considered for implementation in other communities. Collectively, they provide a comprehensive vision for the criminal justice and mental health systems' response to people with mental illness. To appreciate this vision (and the range of measures that exist to begin to address the problem) and to inform an agent of change's decision of where to start, reading the entire report—regardless of the reader's area of expertise—is essential.

Unless efforts in a jurisdiction to improve the response to people with mental illness who are in contact with criminal justice system are already well-advanced, simply becoming familiar with the report's organization and the target population will not make it clear which policy statement to implement first. In fact, each policy statement is a possibility for an agent of change to consider; no single one is an essential first step to initiating change.

It will be tempting for some readers to focus only on the implementation of those policy statements over which they have the most influence. Police professionals, for example, will likely gravitate toward those policy statements that address law enforcement's contact with people with mental illness. Prosecutors may quickly fast-forward to Policy Statement 9: Prosecutorial Review of Charges.

Although focusing the application of the report in a community to a limited number of policy statements, at least at the outset, is probably advisable, readers should not overlook a central message of this document: actions that law enforcement, courts, or corrections officials take have ramifications for the entire criminal justice system. For example, how a police officer responds to an incident involving a person with a mental illness informs the decision that a

State and local government officials will likely be wary of implementing many of the policy statements in this report, which may appear to hinge on the infusion of new federal, state, or local funds. Practitioners, policy-makers, and advocates, however, should not allow such concerns to stifle plans for new programs, policies, and legislation.

As indicated earlier in the introduction, the resources that the criminal justice and mental health systems currently allocate to arrest, hospitalize, prosecute, and incarcerate people with mental illness who are in contact with the criminal justice system is staggering. For example, officials in King County, Washington determined that, over the course of one year, 20 individuals were repeatedly hospitalized, jailed, or admitted to detoxification centers, costing the county approximately \$1.1 million.²⁵

Experience in Chicago, Illinois is one of the many examples that demonstrate that an effective program can have a dramatic impact on jail and hospital expenditures. Staff from the Thresholds Jail Program, which provides case management for people with mental illness released from jail, calculated the number of days that 30 people who had been through the program were incarcerated and/or hospitalized in the year after their participation in the program. In total, the 30 individuals spent approximately 2,200 days less in jail (at \$70/day) than they had during the year preceding their participation in Thresholds. These same 30 people also spent about 2,100 fewer days (at \$500/day) in hospitals.²⁶ Although this significant savings in jail and hospital days (which, on paper, equals about \$1.1 million) is not necessarily realized in reduced budget costs to any agency, it does effect a vastly improved use of resources for the jail and area hospitals.

Many of the examples cited in this report have demonstrated a reduction in jail and hospital days for people with mental illness who had formerly cycled among various institutions. These jail, prison, and hospital beds are among the most expensive resources available to the criminal justice and public health systems. In sum, when it comes to people with mental illness and the criminal justice system, policymakers simply can't afford not to do business differently.

25. Information provided by Patrick Vanzo, Section Chief, Crisis and Engagement Services, Mental Health, Chemical Abuse and Dependency Services Division, King County Dept. of Community and Human Services.

26. Information available at: www.thresholds.org.

prosecutor makes in charging the defendant, which, in turn, is an important factor a judge will take into account when setting bail. Corrections administrators rely on information obtained during the pretrial phase and at sentencing to develop a treatment plan while the inmate is incarcerated; reports regarding the extent to which such a plan is successful inform community corrections authorities' release decisions and plans for supervision of a person with mental illness released to the community.

Considering the implementation of the policy statements that, on their face, appear to address the mental health system only is also essential. Just as criminal justice professionals must appreciate a system-wide response to the problem, so must they appreciate what needs to happen for the mental health system to be *accessible* and *effective*. A community mental health system that does not meet these two criteria is unlikely to successfully engage an individual with mental illness in treatment, and thus will quickly cause criminal justice officials to lose confidence in the community's capacity to support people with mental illness.

Policy makers (such as legislators or county executives) whose authority spans many or all of the recommendations in the report, will wonder which policy statement to implement first. For them and other agents of change, deciding where to start—especially when familiar with the existing obstacles to improving the systems—can be difficult. In more than one community, reform efforts have been derailed before really getting under way because those involved could not decide where to begin. Similarly, attempting to implement many or all of the policy statements in this report at once could overwhelm a community.

Aside from differences in the size and nature of the jurisdictions where the problem plays out, there is great variability in the history, politics, resources, and leadership of each community. These are the factors that typically steer agents of change to distinct policy statements.

The single, most significant common denominator shared among communities that have successfully improved the criminal justice and mental health systems' response to people with mental illness is that each started with some degree of cooperation between at least two key stakeholders—one from the criminal justice system and the other from the mental health system. Accordingly, deciding where to begin will depend on the people brought together to address the problem and the resources available to them in their community.

In sum, sparking a dialogue and cultivating a relationship between criminal justice and mental health stakeholders is, for those communities where such collaboration does not already exist, where the agent of change should start. Similarly, criminal justice or mental health professionals should avoid forging ahead with the implementation of a particular policy statement with-

out first ensuring that their action plan has taken into account the implications for the entire criminal justice and mental health systems.

For these reasons, getting started translates into facilitating communication and building cooperation among criminal justice and mental health stakeholders. A precedent for such cooperation and communication that involves criminal justice or mental health stakeholders exists in nearly every community. Indeed, policymakers and practitioners typically appreciate the value of collaboration, and they invariably have some experience seeding or maintaining an effort that depends on two or more organizations working together.

Still, effecting collaboration between the criminal justice and mental health systems can be particularly vexing. Accordingly, the remainder of this introduction reviews important issues to consider for communities where representatives of the two systems have yet to begin working together or where such efforts have stalled.

Recognizing the Complexities of the Mental Health System

Exploratory discussions with stakeholders in the mental health system will, sooner or later, focus on their capacity to make mental health services available to those who need them most. Before an agent of change reaches out to representatives of the mental health system, it is essential that he or she appreciate how the mental health system works.

As mentioned earlier, the advent of new treatments and service system models is, in many ways, revolutionizing the mental health system. No less dramatic has been the change in orientation from grim acceptance of the supposed irreversibility of the decline associated with mental illness that characterized all thinking about the condition just a few decades ago to the burgeoning belief in recovery today expressed by researchers, clinicians, advocates, families, and—most of all—consumers. Recognition that people with mental illness can and do get better has given hope to many individuals. It is also changing the way people think and talk about mental illness and thus altered the course of policy.

With a foundation of hope and recovery, the system sees reintegration into the community as perhaps its highest priority. Clinical decisions, funding structures, and other incentives are aligned in many places to direct people with mental illness toward community integration. Administrators, advocates, consumers, and experts see hospitalization as a costly alternative residing at the far end of a continuum that should include a rich offering of community-based interventions. Agreement in the field dissolves, however, when stakeholders discuss where to turn when mental health treatment systems have failed to successfully engage an individual in treatment. Conflicting views on involun-

"Remarkable treatments exist, and that's good. Yet many people—too many people—remain untreated. Some end up addicted to drugs or alcohol. Some end up on the streets, homeless. Others end up in our jails, our prisons, our juvenile detention facilities."

**PRESIDENT
GEORGE W. BUSH**

Source: Remarks by the President on Mental Health, April 29, 2002.

University of New Mexico Continuing Education Conference Center
Albuquerque, New Mexico

tary commitment illustrate this tension. Some see involuntary inpatient or outpatient treatment as the ultimate intrusion, a dehumanizing deprivation of rights to be avoided at all costs. Others hail involuntary treatments as necessary and lifesaving tools that must be employed when an individual's judgment is impaired. Most in the field feel torn and seek a balance that respects both realities.

The trend away from hospitalization and the embrace of recovery have led to a new view of the place of control in mental health treatment. Just as laws and policies in effect in most states steer mental health clients toward treatment in the "least restrictive setting," so do treatment professionals speak of ensuring patients the greatest possible degree of control over their own treatment choices. In recent years, mental health advocates and professionals have reexamined the use of coercive measures in mental health treatment settings. Many practitioners have worked hard, for example, to reduce the use of restraints and punitive seclusion in clinical settings, recognizing that they have no therapeutic value and can only be justified when physical safety is at issue, and laws and regulations have been rewritten to reflect this new understanding. Appreciating the mental health system's views regarding coercion may be particularly difficult for someone working in the criminal justice system, where coercion is inherent at every juncture to ensure people obey laws and follow rules. Yet, the use—and perceived use—of coercion has become the subject of much concern and debate within the mental health community. Most of the recommendations offered in this report address issues that arise when people with mental illness are in contact with—or are under control of—the criminal justice system, and they reflect the powers at that system's disposal. By the same token, the report takes into account the mental health system's values and largely steers away from making recommendations that would apply coercive measures to people with mental illness on whom the criminal justice system has no hold.

In addition to understanding key values of the mental health system, an agent of change should become familiar with its complex organizational structure. Understanding how a system is organized largely depends on learning how it is funded. When it comes to the mental health system, this can be a true challenge. No rational organization chart can possibly be drawn that accurately depicts the administration and delivery of mental health services in this country. In contrast to the criminal justice system, which has a fairly straightforward structure, the mental health system draws revenue from a dizzying variety of sources: Medicaid, Medicare, state general revenue funds, local matches, federal Mental Health Block Grants (grants administered by three or more federal agencies), and patient fees, just to name those most common. In some states, funds are funneled through managed-care frameworks. In others,

counties present an additional level of administration. “System,” indeed, may be a misnomer for what is often a patchwork of programs, services, and complex funding structures.

Solutions to many of the problems encountered by the criminal justice system might logically be found in the mental health system. Sadly, the mental health system in too many places has been too beset by internal challenges and lack of support to address some of the most visible signs of its failure. For the public mental health system to assist the criminal justice system in addressing the needs of people with mental illness, policymakers and community change agents will need to ensure that it has sufficient resources and public support.

Getting Criminal Justice and Mental Health Stakeholders to the Table

In some jurisdictions, the greatest challenge to initiating successful cross-system collaboration is simply getting prospective partners to the table. Often, successfully assembling key leaders in the jurisdiction depends on the stakeholders appreciating what the improved collaboration can produce.

Benefits likely to appeal to key leaders in the mental health and criminal justice system include the following:

- Improve the lives of people with mental illness and reduce the frequency of their contact with the criminal justice system
- Enhance public safety
- Use criminal justice resources more efficiently
- Improve the safety of line staff and of the environment in which they work
- Reduce taxpayer expenditures
- Increase public confidence in the justice system
- Gain access to resources
- Enlist allies capable of attracting support from policymakers previously unmoved by the need to bolster the mental health system.

In addition to these gains, collaborative discussions will themselves increase understanding and reduce the assignment of blame. Tight budgets and growing problems have led to friction among criminal justice practitioners, mental health professionals, and advocates in many communities. Bringing all parties together to address the problems can be painful, but it is the only way to engage in problem solving effectively.

27. California Board of Corrections, *Mentally Ill Offender Crime Reduction Grant Program: Annual Report June 2000*, Available at: www.bdcorr.ca.gov/cppd/miocrg/miocrg_publications/miocrg_publications.htm

There are concrete means of eliciting commitments from stakeholders to work together. Making funding support contingent on such cooperation is one way. For example, in California, the legislature sought to foster a collaborative response to the inappropriate involvement of individuals with mental illness with the criminal justice system by establishing crime reduction grants. To receive these grants, counties must create a diverse strategy committee to develop a comprehensive plan of cost-effective measures to reduce crime and the criminal justice costs associated with individuals with mental illness.²⁷

Legislation also can prompt joint ventures through the establishment of task forces, which bring together all relevant stakeholders and develop a foundation for future cross-system partnerships to improve the criminal justice system's response to people with mental illness. An increasing number of state legislatures (and in some cases governors) have taken such steps.

For example, in Colorado, following several independent studies of mental illness in the criminal justice population, the state general assembly created a task force to examine how people with mental illness in the criminal justice system are treated. This task force consisted of more than two dozen members, including representatives from the judicial system, the corrections system, local law enforcement, mental health services, the legal community, consumers, and family members of consumers. The general assembly also established a six-member legislative oversight committee that monitors the work of the task force and submits annual reports, including legislative proposals.²⁸

Sometimes opportunities to engage potential partners and to form a core group of prospective partners emerge from a high-visibility incident. A well-publicized tragedy involving a person with a mental illness and the criminal justice system often generates an atmosphere of crisis, in which elected officials feel pressured to promote quick solutions, which are likely to overlook complex, effective responses. Accordingly, decision makers should use such incidents to stimulate follow-up responses that are long term and thoughtful. To that end, in the wake of such tragedies, community and government leaders should ensure that organizations begin discussions about working together more closely.

A tragedy in Seminole County, Florida, in 1998 prompted such a response. A deputy in the sheriff's office was shot and killed as he approached the residence of Alan Singletary, who had a history of mental illness and whose family had for years sought help for him. After a 13-hour standoff, Singletary was also killed. This tragic incident highlighted many of the deficiencies of Seminole County's mental health delivery systems that are common to many communities: inadequate coordination of services, lack of resources, and insufficient information available to officers in the field and at the scene of a crisis. In

28. The task force was subsequently instructed to examine ways to improve the treatment of persons with mental illness who are detained in pretrial detention facilities. The task force was also instructed to examine the treatment of

mentally ill individuals in the juvenile justice system. See www.state.co.us/gov_dir/leg_dir/lcsstaff/2001/comsched/01MICJSched.htm#committee

response, the sheriff established a task force that meets monthly to discuss system coordination issues as well as potential legislative proposals. The task force includes the state attorney, the public defender, probation officials, the Seminole Community Mental Health Center, representatives of the judiciary and the County Commission, and other various stakeholders. The slain deputy's widow, Linda Gregory, and Alan Singletary's sister, Alice Petree, also serve on this task force.

Defining the Scope of the Problem(s)

Once a core group of stakeholders has made a commitment to improve the criminal justice and mental health systems' response to individuals with mental illness, they need to identify and focus their shared objectives. Leaders of successful partnerships state time and again that, long after launching their joint venture, reminding each other of the mission that originally focused the initiative has enabled them to overcome disagreements or missteps that subsequently threatened the collaboration.

In defining the problem, stakeholders may agree on a limited number of discrete goals, and the problem-solving approach may require a partnership between just two organizations. For example, in Connecticut, the court and the Department of Mental Health and Addiction Services (DMHAS) focused their attention on the inability of judges to obtain a mental health assessment of a defendant or to gain access to mental health treatment for the defendant in a timely manner. (In attempting to address the problem independently, judges were ordering an examination for competency to stand trial, which resulted in the hospitalization of the defendant for a minimum of three weeks.) The partnership between the judiciary and the DMHAS led to the deployment of mental health clinicians to each court to conduct on-site assessments shortly after arrest and to arrange for treatment in the community as a condition of pretrial release.

In some cases, agents of change may determine that the circumstances call for a coalition comprising a diverse group of stakeholders spanning much of the criminal justice and mental health systems. Such a coalition may be necessary when the core group of stakeholders establishes that the problem is large in scope and requires multiple responses. In other cases, leaders in the community may have succeeded in narrowly defining the problem, but they recognize that potential responses (or the issue itself) are controversial and certain to draw the attention of the media. In this event, a broad coalition ensures diverse support for an initiative that could attract criticism.

The success of such groups depends, in part, on the number of stakeholders involved and on the diversity of perspectives—including representatives of criminal justice and mental health entities from state and local government, private mental health professionals, victims, advocates, and consumers and their families—committed to the coalition’s success.

Conducting a Community Audit

A community audit will enable criminal justice officials to identify the mental health system representatives in their jurisdiction—including large and small service providers and those that serve isolated, ethnic, or low-income communities. In conducting this audit, partners should also identify providers outside of the mental health community who deliver services to some of the same clients. Drug treatment providers and low-income housing administrators are two examples.

Good sources for conducting the audit include larger mental health clearinghouses or providers, the Internet, the yellow pages, the news media, and staff within the criminal justice agency. Criminal justice officials should also contact agencies and organizations of which they are members, officers, board members, or trustees. The audit should apply a snowball approach, where identified contacts are asked to contribute names of additional relevant stakeholders.

In addition to leads identified during the local audit, organizations with a national perspective, including national membership associations, can provide some additional valuable referrals.

Ensuring the Investment of the Principals

Whether part of a collaborative effort between just two organizations or a member of a broad-based coalition, each organization should be represented by the chief executive or his or her designee. Involvement by the principals signals to their subordinates and other stakeholders that the organization is committed to the initiative.

The chief executive for a police department (chief, sheriff, or public safety director), the courts (presiding judge), the prosecutor’s office (district attorney), the local jail, or another criminal justice entity is likely to be fairly obvious. The lead individual in mental health circles, however, may be less apparent. Agents of change should turn to existing cross sections of mental health organizations, such as county-level mental health planning committees, for assistance in identifying an appropriate leader in the mental health community.

NEXT STEPS

With a coalition in place and the principals invested in improving the criminal justice system's response to people with mental illness a window of opportunity now exists. Capitalizing on this momentum is essential. In this regard, the subsequent chapters of this report can be extremely helpful. They provide a thorough discussion of the opportunities available to law enforcement professionals, court officials, corrections administrators, and mental health providers to identify and respond appropriately to people with mental illness.