THE TRAGEDY OF CRIMINALIZATION

FLAWED MENTAL HEALTH POLICIES AND

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There are far more people with serious mental illnesses incarcerated in the nation's jails, prisons and juvenile justice facilities than in psychiatric treatment facilities. This is a stark illustration of the extent to which mental health systems across the country have failed those who they are intended to serve.

However, it was not supposed to be this way. When the deinstitutionalization movement was first conceived in the 1950s, community mental health centers were envisioned as programs to effectively address the comprehensive needs of people with serious mental illnesses. Today, looking back through the lens of more than 40 years of experience and history, mental health advocates know that this was a naïve premise. Poorly designed systems, coupled with significant underfunding of mental health services, has resulted in a mental health system that is "in shambles," as stated in the 2002 interim report of President Bush's New Freedom Commission on Mental Health.

The magnitude of the "criminalization" or "transinstitutionalization" of people with mental illnesses is mind-boggling. According to a 1999 Bureau of Justice Statistics report, the U.S. Department of Justice estimates that at least 16 percent, or more than 300,000, of adult inmates in U.S. jails and prisons suffer from serious mental illnesses. By comparison, 5.4 percent of the adult American population is considered to have a "serious mental illness," and about half of these individuals have a "severe and persistent mental illness" — that is to say, schizophrenia, bipolar disorder, major depression, panic disorder and obsessive-compulsive disorder.[1]

For youths, prevalence rates of mental illness in juvenile justice facilities are even higher — federal studies suggest that as many as 60 percent to 75 percent of incarcerated youths have a mental health disorder and 20 percent have a severe disorder.[2] By comparison, according to the 1999 report of the U.S. surgeon general, about 20 percent of youths in the general population are estimated to have mental disorders with at least mild functional impairments, whereas 5 percent to 9 percent of youths have serious emotional disturbances. Incredibly, a recent U.S. congressional report revealed that two-thirds of juvenile justice facilities in the United States hold youths simply for having mental illnesses because there are no suitable mental health treatment alternatives available to them.[3] Why are there so many people with serious mental illnesses in jails and prisons?

INADEQUATE FUNDING AND FLAWED SYSTEMS

The criminalization of people with mental illnesses can be attributed to a multitude of factors, many of them related to flawed public mental health systems. Mental health services and supports are in short supply for youths and adults with mental illnesses in the United States. Even when these services are available, they are often not organized, structured or sufficiently funded to really help the people they are intended to serve.

Youths and adults with serious mental illnesses require multiple services and supports to achieve recovery. Necessary services frequently include medications, intensive outpatient and inpatient mental health services, substance abuse treatment, housing, employment supports (for adults), and educational services and supports (for youths).

Unfortunately, these services are often unavailable, inaccessible or unaffordable to the people who most need them. According to the president's New Freedom Commission on Mental Health, "only one out of two people with a serious form of mental illness seeks treatment for the disorder."[4] The pervasive stigma surrounding these illnesses is clearly a significant deterrent to people seeking the treatment they need. However, when people with these illnesses seek services, they frequently discover that they are not available to them. Several recent studies demonstrate that most people with serious mental illnesses do not have access to even minimally adequate treatment and services.[5]

In addition, even when mental health services and supports are available, they are often fragmented, uncoordinated and inaccessible. The New Freedom Commission, in the section of its 2003 report listing the multiple programs that finance and provide services to people with mental illnesses, reported that "while each program provides essential assistance, together they create a financing approach that is complex, fragmented and inconsistent in its coverage."

A vivid example of two essential systems frequently failing to coordinate services for people with mental illnesses is that of mental health and substance abuse. Prevalence rates of individuals with at least one mental disorder and a co-occurring substance use disorder are extremely high — as high as 7 million to 10 million, according to a 2002 report by the Substance Abuse and Mental Health Services Administration. The evidence is also clear that the most effective way to treat people with co-occurring disorders is through "integrated treatment" — the simultaneous provision of mental health and substance abuse treatment coordinated through a single program.[6] However, there has been significant resistance to developing integrated treatment programs, spurred by concerns about the erosion of valuable funds. Consequently, high-quality, integrated treatment programs are in short supply.

LACK OF CRISIS-RESPONSE CAPABILITIES

Most mental health systems lack the capacity to respond to people when they are in crisis. This is particularly true when the individual in crisis is not known to the local mental health system. It is quite common for family members to call their local mental health system when their loved one is in crisis, only to be told to call the police if they think he or she is dangerous. Thus, local police and sheriff's departments are frequently the first responders to people in crisis — a very difficult job considering that mental health options are frequently unavailable.

DISAPPEARING INPATIENT BEDS

The steady erosion of inpatient psychiatric treatment beds for people requiring acute care services is yet another factor in the criminalization of the mentally ill. As state psychiatric hospital beds have decreased in recent years, the burden of providing acute inpatient psychiatric treatment has increasingly fallen on community hospitals — many of which do not have sufficient beds or staff to meet this need.

Many factors have contributed to this crisis, including continuing lack of adequate mental health benefits in private health insurance, restrictive managed-care practices limiting reimbursement for inpatient care, and critical human resources shortages in the mental health field, particularly skilled psychiatric nurses to treat difficult or hard-to-manage patients.[7] Another factor is an outdated provision in the federal Medicaid law, known as the Institutes for Mental Diseases exclusion, which does not allow federal funds to be used to reimburse treatment in most inpatient psychiatric treatment facilities.

For youths, these problems are even worse. Families of young people experiencing acute psychiatric crises often find that they have no place to turn. Some families have been forced to do the unthinkable — relinquish custody of their children in order to get them the care they need.[8] And without options to respond to youths with severe psychiatric needs, it is no suprise that juvenile justice systems have increasingly had to shoulder this burden.

NONADHERENCE TO TREATMENT

Even when services are available, some people with serious mental illnesses do not use these services. There are many reasons for this, including the unfortunate reality that many people have had bad experiences with mental health treatment systems and are, therefore, understandably reluctant to deal with these systems. Stigma is another factor — accepting treatment means acknowledging one's illness, a very difficult step to take in a society that still frequently shuns and ostracizes people with psychiatric disorders.

There is mounting evidence that, for some people, lack of insight or willingness to acknowledge one's illness and need for treatment may be a symptom of the illness itself. For example, a study of homeless men with schizophrenia at a New York City clinic revealed that 41 percent of these individuals were "moderately unaware" of their illness and need for treatment, and 33 percent were completely unaware. Many of the individuals most impacted by lack of insight are so-called "frequent flyers" — they cycle frequently from hospitals to homelessness to arrest and incarceration.

THIRTY YEARS OF PUNITIVE POLICIES

The growing prevalence of youths and adults with mental illnesses is also an outgrowth of the "get tough on crime" philosophy that has pervaded this country for many years and has resulted in policies such as mandatory-minimum sentencing, three-strikes laws and the general de-valuation of rehabilitation in the corrections field. Due to high rates of co-occurring mental illness and substance abuse, people with serious mental illnesses have particularly been impacted by the imposition of mandatory sentences for drug-related offenses.

INNOVATIONS AND ALTERNATIVES

In recent years, faced with the reality that police have become front-line responders to people in psychiatric crises and jails have become de-facto psychiatric treatment facilities, innovative alternatives have begun to emerge. Criminal justice rather than mental health systems have developed many of these alternatives.

Police Crisis Intervention Teams and Community Triage Programs. More than 10 years ago, the Memphis, Tenn., Police Department, faced with criticism for the fatal shooting of a young man with serious mental illness by the police, developed a program that has won widespread, deserving, national acclaim in the ensuing years. Known as the Memphis Police Crisis Intervention Team (CIT) Program, it is characterized by a strong cooperative relationship between the police and the mental health system. CIT officers, dispatchers and other key police personnel receive intensive training about the signs and symptoms of serious mental illnesses, crisis intervention and de-escalation techniques, and community mental health resources and options. These individuals then translate their knowledge into specific interactions and interventions in the field. Equally important, CIT officers know they have options available to them other than arrest and incarceration. A specialized mental health triage unit at the local university medical center was created in Memphis, specifically to respond to individuals referred by the police. Thus, CIT officers can turn cases over to the triage program and be back out on the street within 10 minutes, a very important consideration for busy police departments. The benefits of the Memphis CIT program have been remarkable, including reduced officer injuries and deaths, fewer arrests and better treatment outcomes.[10] This program has been so successful that it has been emulated in more than 50 communities nationwide, and many other communities have developed alternative law enforcement/mental health triage capabilities.

Mental Health Courts. More than 100 communities across the country have created specialized mental health courts for adult offenders with mental illnesses, and some communities have created these courts for juvenile offenders as well.[11] Although these courts vary in how they operate, they are all designed to link participants with treatment instead of incarceration, provide ongoing supervision over treatment, and they are staffed by dedicated judges, prosecutors, defense

attorneys and mental health personnel. Participation in mental health courts is voluntary — individuals, when deemed competent, may elect to stand trial in lieu of their participation in the mental health court. Depending upon eligibility criteria (most, but not all, mental health courts are limited to individuals charged with misdemeanors or nonviolent felonies), these courts may operate on a deferred prosecution or deferred sentencing model. Although these courts are still in their infancy, early outcome data about these courts are positive.[12]

Wrap-Around Services for Youths. A few communities have developed systems that integrate services and funding of wrap-around services for the most vulnerable youths with mental illnesses. These programs have proven effectiveness in achieving positive clinical results and reducing hospitalizations and involvement with juvenile justice systems.[13] One of these programs in particular, known as WrapAround Milwaukee, is designed specifically to serve children under court orders in the juvenile justice or child welfare systems, and has resulted in sharp reductions in the incarceration of these youths, and at modest costs.[14] The components of this program may include education, mental health, case management and general medical services. Equally as important, the different child service agencies (e.g., education, mental health, juvenile justice, child welfare) work together in an integrated approach to service delivery.

Assertive Community Treatment (ACT) Programs. ACT programs provide a broad and integrated range of services to individuals with severe and persistent mental illnesses, including medications and medication management, case management services, housing assistance, substance abuse treatment, vocational supports and mobile crisis management. ACT programs have proved effective in helping people with the most severe illnesses because they combine all services in one setting and gear these services to the individualized needs of those being served. ACT teams are particularly effective in preventing people in crisis from "falling through the cracks." Thus, not surprisingly, there is a large body of literature documenting the success of these programs in reducing hospitalizations, homelessness, arrests and other consequences of untreated mental illnesses.[15]

Approximately 15 ACT programs have been developed specifically to serve people diverted from jails or reentering communities following incarceration. For example, the Ohio Department of Rehabilitation and Correction funds three ACT teams for individuals with severe and persistent mental illnesses reentering their communities after completing prison sentences.

New Criminal Justice/Mental Health Partnerships. Much of the leadership in developing strategies to reduce the criminalization of people with mental illnesses has come from the criminal justice community. For example, Florida and several other states have developed "partners in crisis" coalitions comprised of criminal justice and mental health leaders to work on improving services for youths and adults with serious mental illnesses. Also, local coalitions have been developed in numerous communities across the country to work on jail diversion, community reentry programs and other strategies to reduce the criminalization of people with mental illnesses.

At a national level, the Criminal Justice/Mental Health Consensus Project, convened by the Council of State Governments, has made a significant impact, both in educating policy-makers about people with mental illnesses involved with criminal justice systems and in promoting local initiatives for change. The comprehensive report developed by the Consensus Project is used by advocates and policy-makers throughout the country as an educational and advocacy tool.[16]

S.1194: The Mentally Ill Offender Treatment and Crime Reduction Act. In October 2004, President Bush signed legislation authorizing federal funds for jail diversion, mental health treatment for inmates with mental illnesses, community reentry services and training. S.1194, which was unanimously supported by Democrats and Republicans alike, represents the first comprehensive federal strategy designed to reduce the unnecessary criminalization of youths and adults with serious mental illnesses. The beauty of the bill is the broadness of its scope — and its recognition that states and communities are best able to develop their own innovative approaches to accomplish the purposes of the bill. However, this new federal program will only achieve its promise if it is adequately funded.[17]

INCARCERATION IS NOT THE ANSWER

Although there are more youths and adults with mental illnesses incarcerated or otherwise involved with criminal justice systems than ever before, there is a silver lining in the clouds. There is an increased awareness that jails are not the right place to treat low-level, nonviolent offenders with mental illness, and much of the impetus for developing alternatives has come from the criminal justice system. The recent enactment of federal legislation to provide resources for addressing this problem reflects growing consensus between conservatives and liberals that incarcerating these individuals serves no useful purpose.

Ultimately, the key to eliminating the widespread criminalization of people with mental illnesses must come from transforming mental health systems and making them more responsive to the people they are charged with serving. The continuing use of jails and prisons as de-facto psychiatric hospitals is neither humane nor cost-effective or good public policy.

ENDNOTES

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[11] See www.mentalhealthcourtsurvey. com for a state-by-state comprehensive description of these courts.

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[14] President's New Freedom Commission on Mental Health. 2003.

[15] National Alliance for the Mentally Ill. 2003. *PACT: Program of Assertive Community Treatment*. Available at www.nami. org.

[16] For more information about the Consensus Project, visit www.consensusproject. org.

[17] The text of S.1194 can be found at http://thomas.loc.gov.

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